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TITLE 23

PUBLIC UTILITIES AND REGULATED INDUSTRIES

(CHAPTERS 1-29 IN VOLUME 22; CHAPTERS 30-59 IN VOLUME 23A; CHAPTERS 74-87 IN VOLUME 24A; CHAPTERS 88-115 IN VOLUME 24B)

SUBTITLE 3. INSURANCE

CHAPTER.

SUBTITLE 3. INSURANCE

CHAPTER 60

GENERAL PROVISIONS

SECTION.

23-60-104. Exceptions — Burial associations — Health care sharing ministries — Definition.

(a) The Arkansas Insurance Code and rules promulgated by the Insurance Commissioner under the Arkansas Insurance Code do not apply to:

(1) Burial associations governed by §§ 23-78-101 — 23-78-119, and 23-78-121 — 23-78-125; or

(2) Health care sharing ministries.

(b) As used in this section, "health care sharing ministry" means a faith-based, nonprofit organization that:

(1) Is tax-exempt under the Internal Revenue Code of 1986;

(2) Limits participation to those who are of a similar faith;

(3) Facilitates an arrangement to match participants who have financial or medical needs to participants with the present ability to assist those with financial or medical needs according to criteria established by the health care sharing ministry;

(4) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;

(5) Establishes contribution amounts for participants with no guarantee of return, assumption of risk, or promise to pay qualified medical needs of the participant or of the medical provider performing the service or services for the participant;

(6) Provides a written monthly statement to its participants that lists:

(A) The total dollar amount of qualified needs submitted to the health care sharing ministry; and

(B) The amount of contribution established for its participants;

(7) Provides a written disclaimer on or accompanying an application and guideline material distributed by or on behalf of the health care sharing ministry that reads, in substance:

"Notice: The organization facilitating the sharing of medical expenses is not an insurance company and neither its guidelines nor plan of operation is an insurance policy. If anyone chooses to assist you with your medical bills, it will be totally voluntary because participants are not compelled by law to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive a payment for medical expenses or if this organization continues to operate, you are always personally responsible for the payment of your own medical bills."; and

(8) Transfers or distributes contribution amounts from one (1) participant to match the qualified medical needs of another participant to whom neither the organization nor the sending participant has an obligation or commitment to pay for any qualified medical needs with its own funds.

History. Acts 1959, No. 148, § 12; A.S.A. 1947, § 66-2012; Acts 2013, No. 1163, § 1.

Amendments. The 2013 amendment added "Burial associations — Health care sharing ministries — Definition" to the section heading; added "and rules promulgated by the Insurance Commissioner under the Arkansas Insurance Code" and made stylistic changes in the introductory language of (a); deleted "and amendments thereto" at the end of (a)(1); and added (a)(2) and (b).

CHAPTER 61

STATE INSURANCE DEPARTMENT

SUBCHAPTER.

Subchapter 1 — General Provisions

SECTION.

Effective Dates. Acts 2013, No. 1499, § 5: July 1, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the oversight and audit of the state's Medicaid program is essential to its continued operation; that the creation of the Office of the Medicaid Inspector General will ensure that fraud, waste, and abuse are found in a timely manner; and that this act is necessary to ensure that state and federal monies are not misspent. Therefore, an emergency is declared to exist, and this act being necessary for the preservation of the public peace, health, and safety shall become effective on July, 1, 2013."

23-61-112. Annual report.

(a) As early in the calendar year as reasonably possible, the Insurance Commissioner annually shall prepare and deliver a report to the Governor showing, with respect to the preceding calendar year:

(1) Names of the authorized insurers transacting insurance in this state, with a summary of their financial statements that the commissioner considers proper;

(2) Names of admitted insurers that closed during the year or entered liquidation, a concise statement concerning the cause for each proceeding, and the amount of assets and liabilities as ascertainable;

(3) The total receipts and expenses of the State Insurance Department for the year;

(4) Other pertinent information and matters the commissioner considers proper.

(b) If the information required under subsection (a) of this section is contained on the state or the department's website under § 25-19-108 or the Arkansas Financial Transparency Act, § 25-1-401 et seq., the report may refer to the web address where the information is located.

History. Acts 1959, No. 148, § 29; A.S.A. 1947, § 66-2114; Acts 2013, No. 355, § 1.

Amendments. The 2013 amendment rewrote the section.

23-61-116. Annual report on health insurance fraud.

Annually on or before March 1, the Insurance Commissioner shall submit to the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Attorney General a report summarizing the State Insurance Department's activities to

investigate and combat health insurance fraud, including without limitation information regarding:

(1) Referrals received;

(2) Investigations initiated;

(3) Investigations completed; and

(4) Other material necessary or desirable to evaluate the department's efforts under this section.

History. Acts 2013, No. 1499, § 3.

Subchapter 2 — Examination of Insurers, Etc.

SECTION.

23-61-206. Examination expense.

(a)(1) Each person examined shall pay to the State Insurance Department the actual travel expenses, reasonable living expense allowance, and compensation for examiners and other persons assisting in the examination according to the examination guidance section in the most current edition of the examiners handbook adopted by the National Association of Insurance Commissioners.

(2) Except as provided in subdivision (a)(1) of this section, the cost of independent professionals used as examiners to assist in an examination under subsection (b) of this section is paid directly by the person examined.

(b)(1) Payments for travel expenses and living expense allowance received by the department for each examination shall be deposited as cash funds.

(2) Reimbursement shall be made from these funds to examiners and others assisting in the examination.

(3) Per diem charges of examiners and others assisting in the examination shall be computed beginning at the time of reporting for duty at the office of the company to be examined and terminating upon completion of the examination or the examiner's active participation therein and to include actual days for travel as certified by the Insurance Commissioner. If air travel is used, only one (1) day's travel time will be authorized. If an automobile is used, travel time allowed shall be computed at the rate of not less than four hundred (400) miles per day as determined by the Rand McNally Road Map, with the actual mileage traveled compensated at the most current rate per mile approved for state employees.

(4) Examiners and others assisting in the examination shall not be reimbursed for travel time or travel expenses not actually incurred in connection with an assignment, nor shall they be reimbursed for dual living expenses while on branch office assignments.

(5) Examiners and others assisting in the examination, when participating in or conducting an examination of a foreign company, shall be authorized to return to their state of domicile every other weekend.

Their expenses will be paid based upon the lesser of airfare or mileage. The reimbursement shall be made in lieu of the per diem allowance. The travel shall be accomplished with a minimum amount of work time lost.

(c) Payments for employee compensation received by the department shall be deposited by the commissioner into the State Treasury to be credited to the State Insurance Department Trust Fund used for the maintenance, operation, and support of the department.

(d) No person shall pay, and no examiner shall accept, any additional emolument on account of any examination.

History. Acts 1959, No. 148, § 35; 1967, No. 433, § 1; 1977, No. 789, § 1; 1983, No. 454, § 1; A.S.A. 1947, § 66-2120; Acts 1991, No. 723, § 7; 1999, No. 881, § 5; 2007, No. 496, § 3; 2013, No. 355, § 2.

Amendments. The 2013 amendment redesignated former (a) as (a)(1), rewrote (a)(1) and added (2).

Subchapter 8 — Arkansas Health Insurance Marketplace Act

A.C.R.C. Notes. Acts 2013, No. 1500, § 3, provided:

"(a)(1) The health insurance marketplace developed through a Federally-facilitated Exchange Partnership model shall transfer to the control of the Arkansas Health Insurance Marketplace on July 1, 2015, if the Board of Directors of the Arkansas Health Insurance Marketplace determines that the establishment of a state-based marketplace is approved by the United States Department of Health and Human Services on or before July 1, 2015.

"(2) The board may extend the date of transfer under subdivision (a)(1) of this section.

"(b) The board shall participate in the Federally-facilitated Exchange Partnership to assist in planning the transition to a state-based health insurance marketplace."

Acts 2013, No. 1500, § 4, provided: "Legislative intent. It is the intent of the General Assembly by the enactment of this act to establish a private, nonprofit, health insurance marketplace."

Effective Dates. Acts 2013, No. 1500, § 5: Apr. 23, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, allow each state to establish a health insurance marketplace or opt to participate in a health insurance marketplace operated by the United States Department of Health and Human Services; that the state has elected to create a state-based marketplace effective on July 1, 2015; and that this act should become effective at the earliest opportunity to begin the process of planning for the implementation of a state-based marketplace and transitioning to a state-based marketplace. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The

date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-61-801. Title.

This subchapter shall be known and may be cited as the "Arkansas Health Insurance Marketplace Act".

History. Acts 2013, No. 1500, § 1.

23-61-802. Definitions.

As used in this subchapter:

(1) "Federal act" means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on April 23, 2013;

(2)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(B) "Health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or both;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or a combination of these; or

(iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on April 23, 2013.

(D) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or

contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on April 23, 2013;

(ii) Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or

(iii) Similar supplemental coverage provided to coverage under a group health plan;

(3) "Health insurance" means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Coverage only for limited scope vision benefits;

(I) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(J) Coverage for specified disease or critical illness;

(K) Hospital indemnity or other fixed indemnity insurance;

(L) Medicare supplement policies;

(M) Medicare, Medicaid, or the Federal Employee Health Benefit Program;

(N) Coverage only for medical and surgical outpatient benefits;

(O) Excess or stop-loss insurance; and

(P) Other similar insurance coverage:

(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or

(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191,

and existing on April 23, 2013, under which benefits for healthcare services are secondary or incidental to other insurance benefits;

(4) "Health insurer" means an entity that provides health insurance or a health benefit plan in the State of Arkansas, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(5) "Qualified employer" means a small employer that elects to make its full-time employees eligible for one (1) or more qualified health plans offered through the small business health options program, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(A) Has its principal place of business in this state and elects to provide coverage through the small business health options program to all of its eligible employees, wherever employed; or

(B) Elects to provide coverage through the small business health options program to all of its eligible employees who are principally employed in this state;

(6) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act; and

(7)(A) "Small employer" means an employer that employed an average of not more than fifty (50) employees during the preceding calendar year.

(B) For purposes of this subdivision (7):

(i) All persons treated as a single employer under subsection (b), subsection (c), subsection (m), or subsection (o) of section 414 of the Internal Revenue Code of 1986 as existing on April 23, 2013, shall be treated as a single employer;

(ii) An employer and any predecessor employer shall be treated as a single employer;

(iii) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

(iv) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that the employer will employ on business days in the current calendar year; and

(v) An employer that makes enrollment in qualified health plans available to its employees through the small business health options program and would cease to be a small employer because of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this subchapter as long as it continuously makes enrollment through the small business health options program available to its employees.

History. Acts 2013, No. 1500, § 1.

23-61-803. Arkansas Health Insurance Marketplace.

(a) There is created a nonprofit legal entity to be known as the "Arkansas Health Insurance Marketplace".

(b)(1) The Arkansas Health Insurance Marketplace is created as a political subdivision, instrumentality, and body politic of the State of Arkansas and, as such, is not a state agency.

(2) Except to the extent provided by this subchapter, the Arkansas Health Insurance Marketplace is exempt from:

(A) All state, county, and local taxes; and

(B) All laws other than the Freedom of Information Act of 1967, § 25-19-101 et seq., governing state agencies, including without limitation:

(i) The Arkansas Procurement Law, § 19-11-201 et seq.;

(ii) The Uniform Classification and Compensation Act, § 21-5-201 et seq.; and

(iii)*(a)* The Arkansas Administrative Procedure Act, § 25-15-201 et seq.

(b) The Arkansas Health Insurance Marketplace shall adopt policies, procedures, and rules to implement its obligations under this subchapter.

(3)(A) Prior to the adoption, amendment, or repeal of any policy, procedure, or rule, the Arkansas Health Insurance Marketplace shall:

(i)*(a)* Give at least thirty (30) days' notice of its intended action. The thirty-day period shall begin on the first day of the publication of notice.

(b) The notice shall include a statement of the terms or substance of the intended action or a description of the subjects and issues involved and the time, the place where, and the manner in which interested persons may present their views on the intended action or the subjects and issues involved.

(c) The notice shall be mailed to any person specified by law and to all persons who have requested advance notice of rule-making proceedings.

(d)(1) Unless otherwise provided by law, the notice shall be published in a newspaper of general daily circulation for three (3) consecutive days and, when appropriate, in those trade, industry, or professional publications that the Arkansas Health Insurance Marketplace may select.

(2) The notice shall be published by the Secretary of State on the Internet for thirty (30) days in accordance with § 25-15-218;

(ii)*(a)* Afford all interested persons at least thirty (30) days to submit written data, views, or arguments, orally or in writing. The thirty-day period shall begin on the first day of the publication of notice under subdivision (b)(3)(A)(i)*(a)* of this section.

(b) Opportunity for oral hearing shall be granted if requested by twenty-five (25) persons, by a governmental subdivision or agency, or by an association having no fewer than twenty-five (25) members.

(c) The Arkansas Health Insurance Marketplace shall fully consider all written and oral submissions concerning the proposed rule before finalizing the language of the proposed rule and filing the proposed rule as required by subdivision (b)(3)(E) of this section.

(d) Upon the adoption, amendment, or repeal of a policy, procedure, or rule, the Arkansas Health Insurance Marketplace, if requested to do so by an interested person either prior to adoption, amendment, or repeal or within thirty (30) days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, amendment, or repeal, incorporating therein its reasons for overruling the considerations urged against its adoption, amendment, or repeal; and

(iii) Comply with § 25-15-301 et seq. [Repealed].

(B) The thirty-day periods for giving public notice under subdivision (b)(3)(A)(i)*(a)* of this section and for receiving written data, views, or arguments, orally or in writing, under subdivision (b)(3)(A)(ii)*(a)* of this section shall run concurrently.

(C)(i) If the Arkansas Health Insurance Marketplace finds that imminent peril to the public health, safety, or welfare or compliance with federal laws or regulations requires adoption of a policy, procedure, or rule upon less than thirty (30) days' notice and states in writing its reasons for that finding, it may proceed without prior notice or hearing, or upon any abbreviated notice and hearing that it may choose, to adopt an emergency rule.

(ii) The rule may be effective for no longer than one hundred twenty (120) days.

(iii) If, after the expiration of the effective period of an emergency rule, the Arkansas Health Insurance Marketplace wishes to adopt a successive emergency rule that is identical or substantially similar to the expired emergency rule, the Arkansas Health Insurance Marketplace shall not adopt the successive emergency rule earlier than thirty (30) days after the expiration of the emergency rule.

(D)(i) The Arkansas Health Insurance Marketplace shall file with the Arkansas Health Insurance Marketplace Legislative Oversight Committee, the Secretary of State, the Arkansas State Library, and the Bureau of Legislative Research a copy of each policy, procedure, or rule adopted by it and a statement of financial impact for the rule.

(ii) The Secretary of State shall keep a copy of each policy, procedure, or rule filed under subdivision (b)(3)(D)(i) of this section in the permanent register required under § 25-15-204(d)(2).

(iii)*(a)* The scope of the financial impact statement shall be determined by the Arkansas Health Insurance Marketplace but, at a minimum, shall include the estimated cost of complying with the policy, procedure, or rule and the estimated cost for the Arkansas Health Insurance Marketplace to implement the policy, procedure, or rule.

(b) If the Arkansas Health Insurance Marketplace has reason to believe that the development of a financial impact statement will be so speculative as to be cost prohibitive, the Arkansas Health Insurance Marketplace shall submit a statement and explanation to that effect.

(c) If the purpose of an Arkansas Health Insurance Marketplace policy, procedure, or rule is to implement a federal rule or regulation, the financial impact statement shall be limited to any incremental additional cost of the state policy, procedure, or rule, as opposed to the federal rule or regulation.

(E)(i)*(a)* Each policy, procedure, or rule adopted by the Arkansas Health Insurance Marketplace is effective thirty (30) days after the filing of the final policy, procedure, or rule unless a later date is specified by law or in the rule itself.

(b) A final rule shall not be filed until the thirty-day public comment period required under subdivision (b)(3)(A)(ii)*(a)* of this section has expired.

(c)(1) After the expiration of the thirty-day public comment period and before the effective date of the rule, the Arkansas Health Insurance Marketplace shall take appropriate measures to make the final rule known to the persons who may be affected by the rule.

(2) Appropriate measures shall include without limitation posting the following information on the Arkansas Health Insurance Marketplace's website:

(A) The final rule;

(B) Copies of all written comments submitted to the Arkansas Health Insurance Marketplace regarding the rule;

(C) A summary of all written and oral comments submitted to the Arkansas Health Insurance Marketplace regarding the rule and the Arkansas Health Insurance Marketplace's response to those comments; and

(D) The proposed effective date of the final rule.

(ii)*(a)* However, an emergency rule may become effective immediately upon filing or at a stated time less than thirty (30) days after filing if the Arkansas Health Insurance Marketplace finds that this effective date is necessary because of imminent peril to the public health, safety, or welfare.

(b) The Arkansas Health Insurance Marketplace's finding and a brief statement of the reasons for the finding shall be filed with the rule.

(c) The Arkansas Health Insurance Marketplace shall take appropriate measures to make emergency rules known to the persons who may be affected by the emergency rules.

(F) The Arkansas Health Insurance Marketplace Legislative Oversight Committee shall review the proposed revised or amended policy, procedure, or rule and, if it is believed that the rule or regulation is contrary to legislative intent, shall file a statement thereof with the Legislative Council.

(c) The Arkansas Health Insurance Marketplace shall operate subject to the supervision and control of the Board of Directors of the Arkansas Health Insurance Marketplace. The board shall consist of the following members to be appointed on or before July 1, 2013:

(1)(A) Three (3) members appointed by the Governor.

(B) One (1) member appointed by the Governor shall be a representative of insurance agents or brokers licensed to sell health insurance in the State of Arkansas.

(C) Two (2) members appointed by the Governor shall be consumer representatives;

(2)(A) Three (3) members appointed by the President Pro Tempore of the Senate.

(B) One (1) of the members appointed by the President Pro Tempore of the Senate shall be a representative of a health insurer.

(C) One (1) of the members appointed by the President Pro Tempore of the Senate shall be a representative of small employers;

(3)(A) Three (3) members appointed by the Speaker of the House of Representatives.

(B) One (1) of the members appointed by the Speaker of the House of Representatives shall be a representative of a health insurer.

(C) One (1) member appointed by the Speaker of the House of Representatives shall be a member of a health-related profession licensed in the State of Arkansas;

(4) The Insurance Commissioner or his or her designee; and

(5) The Director of the Department of Human Services or his or her designee.

(d)(1)(A) The initial members appointed by the Governor under subdivision (c)(1) of this section shall serve terms as follows:

(i) One (1) initial member shall be appointed to a term of four (4) years;

(ii) One (1) initial member shall be appointed to a term of six (6) years; and

(iii) One (1) initial member shall be appointed to a term of eight (8) years.

(B) A member subsequently appointed to the board under subdivision (c)(1) of this section shall serve a term of six (6) years.

(2)(A) The initial members appointed by the President Pro Tempore of the Senate under subdivision (c)(2) of this section shall serve terms as follows:

(i) One (1) initial member shall be appointed to a term of four (4) years;

(ii) One (1) initial member shall be appointed to a term of six (6) years; and

(iii) One (1) initial member shall be appointed to a term of eight (8) years.

(B) A member subsequently appointed to the board under subdivision (c)(2) of this section shall serve a term of six (6) years.

(3)(A) The initial members appointed by the Speaker of the House of Representatives under subdivision (c)(3) of this section shall serve terms as follows:

(i) One (1) initial member shall be appointed to a term of four (4) years;

(ii) One (1) initial member shall be appointed to a term of six (6) years; and

(iii) One (1) initial member shall be appointed to a term of eight (8) years.

(B) A member subsequently appointed to the board under subdivision (c)(3) of this section shall serve a term of six (6) years.

(e) The appointing authorities under this section shall ensure that a majority of the voting members of the board have relevant experience in:

(1) Health benefits administration;

(2) Healthcare finance;

(3) Health plan purchasing;

(4) Healthcare delivery system administration; or

(5) Public health or health policy issues related to the small group and individual markets and the uninsured.

(f) The board shall select one (1) of its members as chair.

(g)(1) Subject to review by the Arkansas Health Insurance Marketplace Legislative Oversight Committee, the board may authorize by a majority vote of the total membership of the board cast during its first regularly scheduled meeting of each calendar year:

(A) Payment to its members of a stipend per day not to exceed one hundred dollars ($100) for each meeting attended or for any day while performing substantive business of the board; and

(B) Reimbursement of actual expenses while performing substantive business of the board.

(2) Members of the board shall receive no other compensation, expense reimbursement, or in-lieu-of payments.

(h)(1) The board shall hire the Executive Director of the Arkansas Health Insurance Marketplace to:

(A) Plan and administer the Arkansas Health Insurance Marketplace; and

(B) Employ necessary staff.

(2) The board may plan and administer the Arkansas Health Insurance Marketplace and employ necessary staff on an interim basis until the executive director is hired.

(3) The employees of the Arkansas Health Insurance Marketplace are not eligible to participate in the Arkansas Public Employees' Retirement System under § 24-4-101 et seq.

(i)(1) Neither the board nor its employees shall be liable for any obligations of the Arkansas Health Insurance Marketplace.

(2) The board may provide in its bylaws or rules for indemnification of and legal representation for the board members and board employees.

(j)(1) The board shall adopt articles, bylaws, and operating rules in accordance with this subchapter within ninety (90) days after the appointment of the board.

(2) The articles, bylaws, and operating rules shall be reviewed by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.

(k) The board shall keep an accurate accounting of all activities, receipts, and expenditures on behalf of the Arkansas Health Insurance Marketplace and report to the Arkansas Health Insurance Marketplace Legislative Oversight Committee as requested by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.

(l)(1)(A) On and after July 1, 2015, the board shall have the authority to apply for and expend on behalf of the Arkansas Health Insurance Marketplace any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.

(B) Before July 1, 2015, the board shall coordinate with the Insurance Commissioner the application for state, federal, or private grant funds to plan, implement, and operate the Arkansas Health Insurance Marketplace.

(2)(A) Before July 1, 2015, the Insurance Commissioner may apply for any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace.

(B) If the Insurance Commissioner applies for and receives any state, federal, or private grant funds available to assist with the implementation and operation of the Arkansas Health Insurance Marketplace, the Insurance Commissioner shall enter into a memorandum of understanding with the Arkansas Health Insurance Marketplace concerning the use and expenditure of the grant funds.

(m)(1) The board may contract with eligible entities to assist with the planning, implementation, and operation of the Arkansas Health Insurance Marketplace.

(2) For purposes of this subsection:

(A) An eligible entity includes without limitation an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities to be assumed by the entity; and

(B) A health insurer or an affiliate of a health insurer is not an eligible entity.

(3) In contracting with an eligible entity under subdivision (m)(1) of this section, the board shall give preference to eligible entities that have relevant experience.

(4)(A) The board shall establish a competitive bidding process for awarding contracts under this subchapter to an eligible entity.

(B) The competitive bidding process for awarding contracts under this subchapter to an eligible entity shall be reviewed by the Arkansas Health Insurance Marketplace Legislative Oversight Committee.

(n) The board may enter into information-sharing agreements with federal and state agencies and other state marketplaces to carry out its responsibilities under this subchapter, provided such agreements:

(1) Include adequate protections with respect to the confidentiality of the information to be shared; and

(2) Comply with all applicable state and federal laws and regulations.

(o) As a condition of participating in the Arkansas Health Insurance Marketplace, a health insurer shall pay the assessments, submit the reports, and provide the information required by the board or the Insurance Commissioner to implement this subchapter.

(p) The board and any eligible entity under subdivision (m)(1) of this section shall provide claims and other plan and enrollment data to the Department of Human Services and the Insurance Commissioner upon request to:

(1) Facilitate compliance with reporting requirements under state and federal law; and

(2) Assess the performance of the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted, including without limitation the program's quality, cost, and consumer access.

History. Acts 2013, No. 1500, § 1.

A.C.R.C. Notes. In reference to the term, "if enacted", the Health Care Independence Act of 2013, § 20-77-2401 et seq., was enacted by Acts 2013, No. 1498, effective April 23, 2013.

23-61-804. Duties of Arkansas Health Insurance Marketplace.

The Arkansas Health Insurance Marketplace shall:

(1)(A) Implement procedures and criteria for the certification, recertification, and decertification of health benefit plans as qualified health plans in coordination with the Insurance Commissioner and in compliance with state and federal law.

(B) The procedures and criteria shall comply with applicable:

(i) Federal law;

(ii) Federal waivers obtained by the state to implement the Health Care Independence Program established by the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted; and

(iii) Rules promulgated by the State Insurance Department and the Department of Human Services under the Health Care Independence Act of 2013, § 20-77-2401 et seq., if enacted;

(2) Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(4) Assign a rating to each qualified health plan offered through the Arkansas Health Insurance Marketplace and determine each qualified health plan's level of coverage in accordance with regulations issued by

the Secretary of the United States Department of Health and Human Services under section 1302(d)(2)(A) of the federal act;

(5) Use a standardized format for presenting health benefit options in the Arkansas Health Insurance Marketplace;

(6) Review compensation rates for licensed brokers and agents;

(7) Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of a premium tax credit under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, and any cost-sharing reduction under section 1402 of the federal act;

(8)(A) Establish a small business health options program through which qualified employers may access coverage for their employees.

(B) The small business health options program, without limitation, shall enable a qualified employer to specify a level of coverage so that any of its employees may enroll in a qualified health plan offered through the program at the specified level of coverage;

(9) Subject to section 1411 of the federal act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986 as existing on April 23, 2013, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section of the Internal Revenue Code of 1986 because:

(A) There is no affordable qualified health plan available through the Arkansas Health Insurance Marketplace or the individual's employer covering the individual; or

(B) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(10) Transfer to the Secretary of the United States Department of the Treasury the following:

(A) A list of the individuals who are issued a certification under subdivision (9) of this section, including the name and taxpayer identification number of each individual;

(B) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, because:

(i) The employer did not provide minimum essential coverage; or

(ii) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code of 1986 as existing on April 23, 2013, either to be unaffordable to the employee or not to provide the required minimum actuarial value; and

(C) The name and taxpayer identification number of each individual who:

(i) Notifies the Arkansas Health Insurance Marketplace under section 1411(b)(4) of the federal act that he or she has changed employers; and

(ii) Ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

(11) Provide to each employer the name of each employee of the employer described in subdivision (10)(B) of this section who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(12)(A) Select entities qualified to serve as navigators and award grants to enable navigators to:

(i) Conduct public education activities to raise awareness of the availability of qualified health plans;

(ii) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 as existing on April 23, 2013, and cost-sharing reductions under section 1402 of the federal act;

(iii) Facilitate enrollment in qualified health plans;

(iv) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan or health benefit coverage or a determination under his or her health benefit plan or health benefit coverage; and

(v) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Arkansas Health Insurance Marketplace.

(B) The board shall ensure in the navigator selection process that the navigators are geographically, culturally, ethnically, and racially representative of the populations served; and

(13) Otherwise comply with a requirement the board determines is necessary to obtain or maintain the approval to establish or administer a state-based health insurance marketplace.

History. Acts 2013, No. 1500, § 1.

A.C.R.C. Notes. In reference to the term, "if enacted", the Health Care Independence Act of 2013, § 20-77-2401 et seq., was enacted by Acts 2013, No. 1498, effective April 23, 2013.

23-61-805. Funding — Publication of costs.

(a)(1) The General Assembly shall establish a reasonable initial assessment or user fee and reasonable increases or decreases in the amount of future assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers for the efficient operation of the Arkansas Health Insurance Marketplace.

(2) Beginning October 1, 2014, and annually by October 1 thereafter, the Arkansas Health Insurance Marketplace shall report to the Arkansas Health Insurance Marketplace Legislative Oversight Committee in the manner and format that the committee requires the Arkansas Health Insurance Marketplace's recommendations for the initial assessment or user fee and increases or decreases in the amount of future assessments or user fees and penalties and interest charges for non-

payment of an assessment or user fee charged to participating health insurers.

(3) Beginning January 1, 2015, and annually by January 1 thereafter, the Arkansas Health Insurance Marketplace Legislative Oversight Committee shall review the recommendations of the Arkansas Health Insurance Marketplace under subdivision (a)(1) of this section and report to the President Pro Tempore of the Senate and the Speaker of the House of Representatives the committee's recommendations for the initial assessment or user fee and future increases or decreases in the amount of assessments or user fees and penalties and interest charges for nonpayment of an assessment or user fee charged to participating health insurers.

(b)(1) An assessment may be offset in an amount equal to the amount of the assessment paid to the Arkansas Health Insurance Marketplace against the premium tax payable for the year in which the assessment is levied.

(2) An offset shall not be allowed for a penalty assessed under subsection (c) of this section.

(c)(1) All assessments and fees shall be due and payable upon receipt and shall be delinquent if not paid within thirty (30) days of the receipt of notice of the assessment by the health insurer.

(2)(A) Failure to timely pay the assessment shall automatically subject the health insurer to a penalty not to exceed ten percent (10%) of the assessment plus interest as established under subsection (a) of this section.

(B) The penalty and interest is due and payable within the next thirty-day period.

(3) The Board of Directors of the Arkansas Health Insurance Marketplace and the Insurance Commissioner may enforce the collection of the assessment and penalty and interest in accordance with this subchapter and the Arkansas Insurance Code.

(4) The board may waive the penalty and interest authorized by this subsection if the board determines that compelling circumstances exist that justify a waiver.

(d)(1) The Arkansas Health Insurance Marketplace shall publish the average costs of licensing, regulatory fees, and any other payments required by the Arkansas Health Insurance Marketplace and the administrative costs of the Arkansas Health Insurance Marketplace on an Internet website to educate consumers on such costs.

(2) Information published under subdivision (d)(1) of this section shall include information on moneys lost to waste, fraud, and abuse.

History. Acts 2013, No. 1500, § 1.

Publisher's Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-60-101.

23-61-806. Rules.

(a) The Insurance Commissioner may promulgate rules to implement this subchapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under the federal act.

History. Acts 2013, No. 1500, § 1.

23-61-807. Relation to other laws.

(a) This subchapter is amendatory to the Arkansas Insurance Code.

(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter are applicable to this subchapter.

(c) This subchapter and actions taken by the Arkansas Health Insurance Marketplace under this subchapter shall not be construed to preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.

History. Acts 2013, No. 1500, § 1.

Publisher's Notes. The Arkansas Insurance Code, referred to in this section, was originally enacted by Acts 1959, No. 148. Acts 1959, No. 148, is codified as set out in the note following § 23-60-101.

CHAPTER 63

INSURANCE COMPANIES GENERALLY

SUBCHAPTER.

Subchapter 2 — Authority To Do Business

SECTION.

23-63-201. Certificate of authority required — Exceptions.

(a) No person shall act as an insurer and no insurer shall transact insurance in this state unless authorized by a subsisting certificate of authority issued to it by the Insurance Commissioner except as to such transactions as are expressly otherwise provided for in the Arkansas Insurance Code.

(b) A certificate of authority shall not be required of an insurer with respect to the following:

(1) Investigation, settlement, or litigation of claims under its policies lawfully written in Arkansas, or making change of beneficiary or other modifications of an insurance or annuity contract, or otherwise administering insurance or annuity contracts in force, or liquidation of assets and liabilities of the insurer, other than collection of new premiums, all as resulting from its former authorized operations in Arkansas;

(2) Transactions subsequent to issuance of or relative to a policy covering only subjects of insurance not resident, located, or expressly to be performed in Arkansas at time of issuance, or covering property in course of transportation by land, air, or water to, from, or through Arkansas and including any preparation or storage incidental thereto, and lawfully solicited, written, or delivered outside Arkansas; or

(3) Transactions pursuant to surplus lines coverages lawfully written under § 23-65-101 et seq., the Unauthorized Insurer Process Act, § 23-65-201 et seq., and the Surplus Lines Insurance Law, § 23-65-301 et seq., of the Arkansas Insurance Code.

(c) A foreign insurer may transact business in this state without certificate of authority, for the purpose and to the extent only of investing its funds in Arkansas real estate or securities, by complying with the laws of this state relating to foreign business corporations in general. Such an insurer shall not be subject to any other provisions of the Arkansas Insurance Code.

(d)(1)(A) The commissioner, in his or her reasonable discretion guided by the standards contained in this subsection and consistent with the purposes set forth in this subsection, may issue a special permit to make fixed-dollar life-only annuity agreements with donors to any duly organized domestic or foreign nonstock corporation or association conducted without profit and:

(i) Engaged in active operation for at least five (5) years prior to receiving the permit solely in bona fide charitable, religious, missionary, educational, or philanthropic activities; or

(ii) Not engaged in active operation solely in bona fide charitable, religious, missionary, educational, or philanthropic activities for five (5) years if the commissioner is reasonably satisfied that:

(a) The entity is affiliated with a corporation or association that meets the requirements of subdivision (d)(1)(A)(i) of this section; and

(b) An adequate level of management expertise is readily available to the entity requesting the permit.

(B) The permit authorizes the corporation or association to receive gifts of money or other assets of monetary value that the commissioner may authorize for its agreement to pay an annuity to the donor or the donor's nominee and to carry out the annuity agreement.

(C) Before making an annuity agreement under this subsection, every corporation or association shall file with the commissioner for his or her approval either:

(i) A schedule of its maximum annuity rates that shall be computed on the basis of the annuity standard adopted by it for calculating its reserves; or

(ii) A statement certifying that it adopts and will adhere to the annuity rates as published from time to time by the American Council on Gift Annuities or its successor until the corporation or association advises the commissioner to the contrary in writing and files a schedule of its new proposed maximum annuity rates for approval.

(D) Filings and approvals required under this subsection shall be subject to the provisions of §§ 23-79-109 and 23-79-110.

(2) Upon entering an annuity agreement, a domestic corporation or association shall establish and maintain liabilities with respect to the annuity by one (1) of the following methods, using an amount:

(A) Not less than the present value of future benefits payable to the donor as determined by the most recent method established by the Internal Revenue Service;

(B) Determined by applying the method established for annuities under the Standard Valuation Law for Life Insurance and Annuities, § 23-84-101 et seq.; or

(C) Equal to the aggregate values determined at the dates of contribution of all assets received from donors with respect to annuities for annuitants who are then living.

(3)(A) Unless otherwise permitted by the commissioner, each corporation or association shall maintain a segregated account or accounts for its charitable gift annuities.

(B) The segregated account or accounts shall be used solely to pay the charitable gift annuity obligations of the corporation or association.

(C) If the commissioner finds the reserve established by a permittee inadequate at any time, the commissioner shall order the permittee to increase its reserve accordingly, or the commissioner may stipulate the reserving method for the permittee to rectify the reserve deficiency.

(4) Each corporation or association, except those identified in subdivision (d)(5) of this section, shall maintain net admitted assets at least equal to the greater of:

(A) The sum of its reserves on its outstanding agreements, all other liabilities, and a surplus of at least ten percent (10%) of the reserves; or

(B) The amount of fifty thousand dollars ($50,000).

(5) Each domestic corporation or association maintaining reserves in the manner described in subdivision (d)(2)(C) of this section shall maintain net admitted assets at least equal to the amount of the reserves plus all other outstanding liabilities.

(6) In determining reserves, a deduction shall be made for all or any portion of an annuity risk that is reinsured by a life insurance company authorized to do business in this state.

(7) The required admitted assets shall be invested:

(A) Only in securities permitted by §§ 23-63-801 — 23-63-833, 23-63-835, 23-63-836, 23-63-839, and 23-63-840; or

(B) In accordance with the prudent investor rule stated in §§ 24-2-610 — 24-2-619.

(8) No corporation or association organized under the laws of another state shall be permitted to make annuity agreements in this state unless it complies with all requirements of this subsection imposed upon domestic corporations or associations, except that a corporation or association organized under the laws of another state may invest its reserves and surplus funds in securities permitted by the laws of its state of domicile.

(9)(A) No corporation or association shall make or issue in this state any annuity contract before obtaining a permit issued in accordance with the provisions of this subsection.

(B) If after notice and hearing the commissioner finds that a corporation or association having a permit has failed to comply with the requirements of this subsection, the commissioner may revoke or suspend the permit or order the permittee to cease making new annuity contracts until it complies.

(C)(i) All corporations or associations operating under this subsection shall file an annual financial statement of their operations and accounts and schedule of outstanding annuities with applicable reserves within one hundred eighty (180) days of the end of their fiscal year.

(ii) The report shall be prepared by a certified public accountant in accordance with generally accepted accounting principles detailing the financial condition and status of the corporation or association as of the conclusion of its most recent fiscal year.

(iii) Each domestic corporation or association investing assets in the manner described in subdivision (d)(7)(B) of this section shall file with the annual report:

(a) A description of the organization's investment philosophy for charitable gift annuities and how the investments of the company are designed to meet future charitable gift annuity obligations;

(b) A report from the organization identifying the members of the investment committee charged with making investment decisions regarding charitable gift annuity assets, including a description of each committee member's investment expertise; and

(c) A certification of the board of directors of the corporation or association that attests that its investments and investment transactions match the organization's philosophy and meet the standards of the prudent investor rule stated in §§ 24-2-610 — 24-2-619.

(10) The commissioner may promulgate any rules and regulations the commissioner considers necessary or desirable to implement the provisions of this subsection.

(e)(1) The commissioner shall promulgate rules to allow a city, town, municipality, or county of this state acting independently or in any combination pursuant to an interlocal cooperation agreement under the

Interlocal Cooperation Act, § 25-20-101 et seq., to obtain a charitable annuity permit for the purpose of establishing a charitable annuity program.

(2)(A) The charitable annuity program shall permit any person or an entity to make voluntary and charitable donations to benefit the bona fide charitable, educational, and philanthropic programs, including without limitation libraries, museums, and governmentally owned hospitals, of a city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq.

(B) The charitable donation may be made to assist the establishment or maintenance of streets, parks, children's playgrounds, libraries, museums, beautification projects, or any other charitable, educational, or philanthropic purpose of a city, town, municipality, or county.

(3) The charitable annuity permit shall authorize the city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., to receive unconditional gifts of money and property and to receive gifts of money and property conditioned upon paying an annuity to the donor or the donor's nominee.

(4) The rules of the commissioner to implement this subsection shall provide without limitation:

(A) That the city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., has been actively involved in the operation of the public charitable, educational, or philanthropic activity for at least five (5) years prior to the issuance of the permit;

(B) For the investment of the assets and maintenance of the liabilities and surplus of the charitable annuity program appropriate to funding the annuities;

(C) That separate accounts be maintained solely for the benefit of annuity contract owners;

(D) The prior approval of annuity contract forms and annuity rates by the commissioner; and

(E) Annual financial reporting of a charitable annuity program of a city, town, municipality, or county acting alone or pursuant to an interlocal cooperation agreement under the Interlocal Cooperation Act, § 25-20-101 et seq., that has been granted a charitable annuity permit under this subsection.

(f) The commissioner may punish a person that fails to meet the requirements of subsection (d) or subsection (e) of this section by:

(1) Imposing a penalty of up to ten thousand dollars ($10,000); or

(2) Suspending or revoking the charitable annuity permit and authority to operate under subsection (d) or subsection (e) of this section.

History. Acts 1959, No. 148, §§ 43-45; A.S.A. 1947, §§ 66-2201 — 66-2203; Acts 1993, No. 1147, § 1806; 2003, No. 1099, § 1; 2005, No. 905, § 1; 2007, No. 496,

§ 8; 2009, No. 726, §§ 12 – 16; 2013, No. 355, § 3.

Amendments. The 2013 amendment rewrote (d)(1)(B).

23-63-216. Annual statement and other information.

(a)(1) Annually on or before March 1 or within an extension of time that the Insurance Commissioner for good cause may have granted, each authorized insurer shall file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the December 31 preceding.

(2) The statement shall be the appropriate and most recent National Association of Insurance Commissioners':

(A) "Annual Statement Blank For Life And Accident And Health";

(B) "Property And Casualty Annual Statement Blank";

(C) "Title Insurance Annual Statement Blank";

(D) "Annual Statement Blank for Health" for use by hospital, medical, and dental service or indemnity corporations;

(E) "Fraternal Annual Statement Blank";

(F) "Annual Statement Blank for Health" for health insurers or health maintenance organizations and others; or

(G) Other National Association of Insurance Commissioners' convention blank as appropriate.

(3) The statement shall be prepared in accordance with the most recent and appropriate companion National Association of Insurance Commissioners' "Annual and Quarterly Statement Instructions" and follow those accounting practices and procedures prescribed by the most recent and appropriate companion National Association of Insurance Commissioners' Accounting Practices and Procedures Manual.

(4) Arkansas domestic insurers shall file the statement with the commissioner in hard-copy format.

(5) Each authorized insurer shall file an audited financial statement on or before June 1 of each year.

(6) Authorized foreign and alien insurers complying with subsection (b) of this section are deemed to have satisfied the requirement to file the statement with the commissioner.

(7) The commissioner may allow a life insurer or property and casualty insurer whose insurance premiums and required statutory reserves for accident and health insurance constitute at least ninety-five percent (95%) of its total premium considerations or total statutory required reserves, respectively, to file the "Annual Statement Blank for Health" as its annual statement with the companion quarterly statement forms.

(8)(A) The National Association of Insurance Commissioners' annual statement convention blank shall be verified by the oath of the insurer's president or vice president and secretary, treasurer, or actuary, as applicable, or if a reciprocal insurer, by its attorney in fact or if a corporation, its like officers.

(B)(i) The statement of an alien insurer shall be verified by the oath of the insurer's United States manager or other officer autho-

rized and shall relate only to its transactions and affairs in the United States unless the commissioner requires otherwise.

(ii) If the commissioner requires a statement as to the alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible.

(C) The commissioner may waive a requirement under this section for verification under oath.

(9)(A) The commissioner may refuse to continue the insurer's certificate of authority, as provided in § 23-63-211, or may suspend or revoke the certificate of authority of an insurer failing to file its annual statement when due.

(B)(i) In addition, the insurer shall be subject to a penalty of one hundred dollars ($100) for each day of delinquency.

(ii) The penalty shall be collected by the commissioner, if necessary, by a civil suit brought by the commissioner in Pulaski County Circuit Court, unless the penalty is waived by the commissioner upon a showing by the insurer of good cause for its failure to file its report on or before the date due.

(10) At the time of filing, the insurer shall pay the fee for filing its annual statement as prescribed by § 23-61-401.

(11) In addition to information called for and furnished in connection with its annual statement, an insurer shall furnish to the commissioner as soon as reasonably possible such information with respect to its transactions or affairs as the commissioner requests in writing.

(12)(A) In accordance with the specifications applicable to annual financial statements, each authorized domestic insurer and health maintenance organization and hospital or medical service corporation, or other domestic licensee so directed by the State Insurance Department in writing shall also file with the commissioner a quarterly financial statement on a form prescribed by the commissioner not later than forty-five (45) days following the end of each of the first three (3) calendar quarters of each year, excepting the fourth quarter of each calendar year, that shall be reconciled in the annual financial statement.

(B) The filing specifications of this section for annual financial reports apply to quarterly financial reports.

(b)(1) In addition to the information required by subsection (a) of this section, a market conduct annual statement shall be filed, when applicable, with the commissioner if:

(A) A property and casualty insurer reports seven million dollars ($7,000,000) or more in homeowner or private passenger automobile gross premiums;

(B) A life and annuity insurer reports seven million dollars ($7,000,000) or more in individual life insurance premiums or annuity gross premiums.

(2) After review of the market conduct annual statement, the commissioner may require additional filing of other market conduct functions information considered relevant.

(c)(1) Insurers shall submit the market conduct annual statement data required by subsection (b) of this section in an electronic format and manner as prescribed by the commissioner. The commissioner may designate the National Association of Insurance Commissioners to receive the market conduct annual statement on his or her behalf, for the purpose of collecting, compiling, aggregating, and reporting on market conduct annual statement data.

(2) Any forms or data submitted by the insurer as market conduct annual statement data under this subsection are deemed to be documents or information obtained from the insurer by the department as examination under § 23-61-207 without the necessity of a formal examination notice under § 23-61-203 or examination report and adoption order under § 23-61-205.

(d)(1)(A) Annually on or before March 1, each domestic, foreign, and alien insurer authorized to transact business in this state shall file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the commissioner as of the December 31 preceding.

(B) The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification.

(C) Any amendments and addendums to the annual statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners.

(2) Foreign insurers that are domiciled in a state with a law substantially similar to this subsection and comply with their state's law are in compliance with this subsection.

(3) In the absence of malice, members of the National Association of Insurance Commissioners, their committees, subcommittees, task forces, delegates, employees, and others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the commissioner under the authority of this subsection and shall not be subject to civil liability for libel, slander, or another cause of action by virtue of their collection, review, and analysis or dissemination of the data and information collected from the filings required in this section.

(4) The commissioner may impose the sanctions set out in subdivision (a)(9) of this section on an insurer failing to file its annual statement with the National Association of Insurance Commissioners when due or within an extension of time that the commissioner for good cause has granted.

(5) Each authorized insurer shall submit its annual and quarterly statement and supplemental information to the National Association of Insurance Commissioners in electronic format as specified by the National Association of Insurance Commissioners.

(e)(1) Each domestic insurer authorized to transact business in this state shall include in its annual statement an opinion, as is relevant to the lines of business the domestic insurer is authorized to write, on its life and health policy and claim reserves and its property and liability loss and loss adjustment expense reserves by a qualified actuary.

(2) The opinion shall be in the format prescribed by the National Association of Insurance Commissioners' Annual and Quarterly Statement Instruction handbook.

History. Acts 1959, No. 148, § 62; 1973, No. 35, § 1; A.S.A. 1947, § 66-2220; Acts 1991, No. 723, §§ 17, 18; 1993, No. 527, §§ 2, 3; 1995, No. 1272, § 12; 1999, No. 301, § 1; 2001, No. 1604, §§ 26-28; 2005, No. 506, § 18; 2009, No. 726, § 18; 2011, No. 760, § 3; 2011, No. 1034, § 1; 2013, No. 355, §§ 4, 5.

Amendments. The 2013 amendment, in (a)(8)(A), inserted "treasurer," deleted "the oath of" preceding "its attorney," and substituted "if a corporation, its like officers" for "its like officers if a corporation"; and rewrote (b).

Subchapter 5 — Insurance Holding Company Regulatory Act

SECTION.

23-63-503. Definitions.

As used in this subchapter:

(1) "Affiliate" of or person "affiliated" with a specific person means a person that directly or indirectly through one (1) or more intermediaries controls, is controlled by, or is under common control with the person specified;

(2)(A) "Control" or "controlling" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person unless the power is due to an official position or corporate office:

(i) Through the ownership of voting securities;

(ii) By contract other than a commercial contract for goods or nonmanagement services; or

(iii) Otherwise.

(B)(i) Control is presumed to exist if a person directly or indirectly owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of another person.

(ii) This presumption may be rebutted by a showing that control does not exist in fact.

(C) After furnishing notice to the persons and the opportunity to be heard, the Insurance Commissioner may determine that control exists in fact, notwithstanding the absence of a presumption to that effect;

(3) An "insurance holding company system" consists of two (2) or more affiliated persons, one (1) or more of which is an insurer. However, for purposes of this subchapter, the term shall not be deemed to include

a domestic insurer or domestic holding company system authorized and doing business solely in this state and which is not affiliated with a foreign or alien insurer;

(4) "Insurer" means the same as defined in § 23-60-102, but "insurer" does not include:

(A) Agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state;

(B) Fraternal benefit societies; or

(C) Nonprofit hospital and medical service corporations;

(5)(A) "Person" includes a corporation, partnership, association, joint-stock company, business trust, unincorporated organization, depository corporation, a similar entity, or a combination of these entities acting in concert.

(B) "Person" does not include a securities broker performing no more than the usual and customary broker's function.

(C) "Person" includes an individual as that term is used in § 23-63-506;

(6) "Security holder" means a person who owns a security of a named person, including:

(A) Common stock;

(B) Preferred stock;

(C) Debt obligations; and

(D) Any other security convertible into or evidencing the right to acquire these securities;

(7) "Subsidiary" means an affiliate of a named person controlled by the person through one (1) or more intermediaries; and

(8) "Voting security" includes a security convertible into or evidencing a right to acquire a voting security.

History. Acts 1971, No. 288, § 3; 1975, No. 729, § 4; A.S.A. 1947, § 66-5003; Acts 1991, No. 723, § 20; 2005, No. 506, § 20; 2009, No. 164, § 15; 2011, No. 887, § 1; 2013, No. 355, § 6.

Amendments. The 2013 amendment rewrote (1); substituted "the direct or indirect possession of" for "to have" in the introductory language of (2)(A); redesignated former (2)(B) as (2)(B)(i) and (2)(B)(ii); and inserted "directly or indirectly" in (2)(B)(i).

Subchapter 13 — Risk-Based Capital Act

SECTION.

23-63-1304. Company action level event.

(a) As used in this subchapter, "company action level event" means any of the following events:

(1) The filing of an RBC report by an insurer that indicates:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) If a life or accident and health insurer, the life or accident and health insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and two and five-tenths (2.5) and has a negative trend; or

(C) For the year ending December 31, 2011, and each year following, if a property and casualty insurer, the property and casualty insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and three (3) and triggers the trend test determined according to the trend test calculation included in the Property and Casualty RBC Instructions;

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates an event in subdivision (a)(1) of this section, if the insurer does not challenge the adjusted RBC report under § 23-63-1308; or

(3) If under § 23-63-1308 an insurer challenges an adjusted RBC report that indicates the event in subdivision (a)(1) of this section, the notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that shall:

(1) Identify the conditions that contribute to the company action level event;

(2) Contain proposals of corrective actions that the insurer intends to take and would be expected to result in the elimination of the company action level event;

(3) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital, and surplus. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component;

(4) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(5) Identify the quality of and problems associated with the insurer's business, including without limitation its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business, and use of reinsurance, if any, in each case.

(c) The insurer shall submit the RBC plan:

(1) Within forty-five (45) days after the company action level event; or

(2) If the insurer challenges an adjusted RBC report under § 23-63-1308, within forty-five (45) days after notification to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(d) Within sixty (60) days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether or not the RBC plan is implemented or is unsatisfactory in the judgment of the commissioner. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall state the reasons for the determination and may state proposed revisions that shall make the RBC plan satisfactory in the judgment of the commissioner. On notification from the commissioner, the insurer shall prepare a revised RBC plan that may incorporate by reference revisions proposed by the commissioner and shall submit the revised RBC plan to the commissioner:

(1) Within forty-five (45) days after the notification from the commissioner; or

(2) If the insurer challenges the notification from the commissioner under § 23-63-1308, within forty-five (45) days after a notification to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner, subject to the insurer's right to a hearing under § 23-63-1308, may specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in a state in which the insurer may do business if:

(1) The state has an RBC provision substantially similar to § 23-63-1309(a); and

(2) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state by the later of:

(A) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date that the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

History. Acts 1995, No. 622, § 1; 2001, No. 1603, § 14; 2011, No. 760, § 4; 2013, No. 1133, § 7.

Amendments. The 2013 amendment substituted "indicates" for "shows" in the introductory language of (a)(1); inserted "life or accident and health" in (a)(1)(B); and, in (a)(1)(C), inserted "the property and casualty insurer," and "determined."

Subchapter 16 — Licensing and Regulation of Captive Insurers

Effective Dates. Acts 2013, No. 461, § 3: Mar. 21, 2013. Emergency clause provided: "It is found and determined by the General Assembly of the State of Arkansas that Arkansas does not have a needed, competitive presence in the field of captive insurance companies and that this act will attract new captive insurance companies to the state; that a delay in permitting applications for new captive insurance companies will hurt the state's economy and cause an unnecessary burden on the Insurance Commissioner. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on: (1) The date of its approval by the Governor; (2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or (3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto."

23-63-1611. Reinsurance.

(a) A captive insurance company may provide reinsurance under the Arkansas Insurance Code, on risks ceded by any other insurer.

(b) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers that are:

(1) Complying with § 23-62-305(a)-(f); or

(2) Not complying with § 23-62-305(a)-(f) upon approval of the captive insurance company's business plan by the Insurance Commissioner.

History. Acts 2001, No. 1391, § 11; 2013, No. 461, § 1.

Amendments. The 2013 amendment rewrote (b).

23-63-1614. Premium tax.

(a) Except as provided in this section, a captive insurance company shall pay to the Insurance Commissioner by March 1 of each year, a tax at the rate of:

(1) Two hundred fifty thousandths of one percent (0.250%) on the first twenty million dollars ($20,000,000);

(2) One hundred fifty thousandths of one percent (0.150%) on the next twenty million dollars ($20,000,000); and

(3) Fifty thousandths of one percent (0.050%) on each dollar thereafter, on the direct premiums collected or contracted for on policies or contracts of insurance written by the captive insurance company during the year ending December 31 next preceding, after deducting from the direct premiums subject to the tax the amounts paid to policyholders as

return premiums, which shall include dividends on unabsorbed premiums or premium deposits returned or credited to policyholders.

(b)(1) Except as provided in this section, a captive insurance company shall pay to the commissioner by March 1 of each year, a tax at the rate of:

(A) Two hundred twenty-five thousandths of one percent (0.225%) on the first twenty million dollars ($20,000,000) of assumed reinsurance premium;

(B) One hundred fifty thousandths of one percent (0.150%) on the next twenty million dollars ($20,000,000);

(C) Fifty thousandths of one percent (0.050%) on the next twenty million dollars ($20,000,000); and

(D) Twenty-five thousandths of one percent (0.025%) of each dollar thereafter.

(2) No reinsurance tax applies to premiums for risks or portions of risks that are subject to taxation on a direct basis under subsection (a) of this section.

(3) A premium tax is not payable in connection with the receipt of assets in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control, if the transaction is part of a plan to discontinue the operations of the other insurer and if the intent of the parties to the transaction is to renew or maintain business with the captive insurance company.

(c) If the aggregate taxes to be paid by a captive insurance company calculated under subsections (a) and (b) of this section amount to less than five thousand dollars ($5,000) in any year, the captive insurance company shall pay a tax of five thousand dollars ($5,000) for that year.

(d) The total tax paid by a captive insurance company shall not exceed one hundred thousand dollars ($100,000) in any year.

(e) A captive insurance company failing to make returns or to pay all taxes required by this section is subject to relevant sanctions under the Arkansas Insurance Code.

(f) Two (2) or more captive insurance companies under common ownership and control must be taxed as though they were a single captive insurance company.

(g) As used in this section, "common ownership and control" means:

(1) In the case of stock corporations, the direct or indirect ownership of eighty percent (80%) or more of the outstanding voting stock of two (2) or more corporations by the same shareholder or shareholders; and

(2) In the case of mutual corporations, the direct or indirect ownership of eighty percent (80%) or more of the surplus and the voting power of two (2) or more corporations by the same member or members.

(h) In the case of a branch captive insurance company, the tax under this section applies only to the branch business of the company.

(i)(1) The tax under this section constitutes all taxes collectible under the laws of this state from a captive insurance company.

(2) No other tax may be levied or collected from a captive insurance company by this state or a county, city, or municipality of this state,

except ad valorem taxes on real and personal property used in the production of income.

(j) This section shall not apply to any producer reinsurance captive insurance company that invests and continuously maintains not less than fifty percent (50%) of its assets in certificates of deposit of any bank organized under the laws of the United States with a banking facility in the State of Arkansas or any federally insured bank or savings institution organized under the laws of the State of Arkansas, or in bonds, notes, warrants, or other securities, not in default, that are direct obligations of:

(1) This state;

(2) Any county, incorporated city or town, or duly organized school district or other taxing district of this state:

(A) If no default on the part of the obligor in payment of principal or interest on any of its obligations has occurred within five (5) years prior to the date of the proposed investment; or

(B) If the obligations were issued less than five (5) years prior to the date of investment, no default in payment of principal or interest has occurred on the obligations to be purchased or on any other public obligation of the obligor within five (5) years of the investment; or

(3) Any local improvement district in this state to finance local improvements authorized by law, if the principal and interest of the obligations are payable from assessments on real property within the local improvement district, and:

(A) No default on the part of the obligor in payment of principal or interest on any of its obligations has occurred within five (5) years prior to the date of the proposed investment; or

(B) If the obligations were issued less than five (5) years prior to the date of investment, no default in payment of principal or interest has occurred on the obligations to be purchased or on any other public obligation of the obligor within five (5) years of the investment.

History. Acts 2001, No. 1391, § 14; 2003, No. 466, § 7; 2013, No. 461, § 2.

Amendments. The 2013 amendment rewrote (a); inserted (d) and redesignated the remaining subsections accordingly.

CHAPTER 64

LICENSEES, AGENTS, BROKERS, ADJUSTERS, AND CONSULTANTS

SUBCHAPTER.

Subchapter 1 — General Provisions

SECTION.

23-64-102. Definitions.

As used in this chapter, unless the context otherwise requires:

(1)(A) An "agent" is an individual, firm, limited liability company, or corporation who is required by the Producer Licensing Model Act, § 23-64-501 et seq., to be licensed as an insurance producer by the Insurance Commissioner.

(B) An agent shall be deemed to be the agent of the appointing insurer;

(2)(A)(i) A "resident agent" is an agent whose residence is in or who may vote in this state or who is licensed as a resident insurance producer by the commissioner in accordance with the Producer Licensing Model Act, § 23-64-501 et seq.;

(ii) Every reference herein to "an agent, a resident of this state" and to "a licensed agent, a resident of this state" shall include any duly licensed resident agent as defined in this section.

(B) By reciprocal arrangements with another state under which residents of Arkansas may be licensed and operate as resident agents of the other state, the commissioner may license, as resident agents of Arkansas, residents of the other state who:

(i) In cities or towns through which passes the Arkansas boundary, or border communities or border trade areas, maintain their principal place of business in that city, town, community, or trade area; and

(ii) Are otherwise qualified for the license.

(C) The terms "border communities" or "border trade areas" shall mean communities and trade areas situated within five (5) miles of the Arkansas boundary.

(D) Firms and corporations of which all the members and persons exercising the license power qualify individually as to residence under the definition in this subdivision (2) may be licensed as resident agents;

(3) A "broker" is an individual, firm, limited liability company, or corporation who is required to be licensed as an insurance producer under the Producer Licensing Model Act, § 23-64-501 et seq., who represents insureds or prospective insureds other than himself or herself or itself and not on behalf of an insurer or agent. A broker shall be deemed to be the agent of the insured;

(4)(A) An "adjuster" is an individual, firm, limited liability company, or corporation who for compensation as an independent contractor or as the employee of an independent contractor or for fee or commission investigates and negotiates, on behalf of the insurer, settlement of claims arising under insurance contracts.

(B) A licensed attorney at law who is qualified to practice law in this state is not deemed to be an "adjuster" for the purposes of this chapter.

(C) A salaried employee of an insurer or of a managing general agent or of any adjustment bureau or association owned and maintained by insurers to adjust losses of member insurers is not deemed to be an "adjuster" for the purposes of this chapter.

(D) A resident agent or marine average adjuster or an agent or broker who adjusts or assists in adjustment of losses arising under policies procured through the broker or issued by the insurer represented by the agent that is appointed by the insurer shall not be deemed to be an "adjuster" for the purposes of this chapter.

(E)(i) The commissioner may issue "limited adjusters' licenses" to persons who are sponsored and are employees of self-insured, self-funded, entities for purposes of the adjustment of claims for or on the behalf of that self-insured sponsoring entity.

(ii) The limited license shall be valid only while the employee is employed by the sponsoring self-insured entity.

(iii) Qualifications, fees, and other aspects of licensure for "limited adjusters' licenses" shall be as established by regulation.

(F)(i) An individual who is an employee of or supervised by a licensed adjuster or agent who is exempt from licensure under subdivision (4)(D) of this section is not an adjuster if the individual, for purposes of portable electronic insurance claims:

(a) Collects claim information from an insured and claimants;

(b) Furnishes claim information to an insured or claimants; and

(c) Conducts data entry through an automated claims adjudication system.

(ii) A single licensed adjuster or licensed agent shall not supervise more than twenty-five (25) persons under this subdivision (4)(F).

(iii) As used in this subdivision (4)(F), "automated claims adjudication system" means a preprogrammed computer system that is:

(a) Designed for the collection, data entry, calculation, and resolution of portable electronics insurance claims;

(b) Used only by:

(1) A licensed independent adjuster;

(2) A licensed agent; or

(3) A supervised individual operating under this chapter;

(c) Compliant with all claim payment requirements of the insurance laws of this state; and

(d) Certified as compliant by a licensed independent adjuster;

(5)(A) An "insurance consultant" is an individual, firm, limited liability company, or corporation which, for a fee, in any manner advises or counsels anyone as to his or her insurance needs and coverages under any insurance policy or contract.

(B) The term "insurance consultant" shall not be deemed to include licensed attorneys, actuaries, certified public accountants, medical bill analysts, or any other person who gives or offers incidental advice to the public in the normal course of a business or professional activity other than insurance consulting; and

(6) For purposes of the commissioner's reciprocal arrangements or agreements with the insurance supervisory officials of other states for

licensure of nonresident insurance applicants as permitted in § 23-64-203 or other applicable laws, the term "insurance producer" means "agent" or "broker", or both, as applicable, as defined in this section.

History. Acts 1959, No. 148, §§ 145-149, 151; A.S.A. 1947, §§ 66-2802 — 66-2806, 66-2808; Acts 1987, No. 622, § 1; 1987, No. 927, § 1; 1987, No. 955, § 1; 1997, No. 1004, § 1; 1999, No. 657, § 1; 2001, No. 580, § 3; 2013, No. 754, § 1.

Amendments. The 2013 amendment added (4)(F).

Subchapter 2 — Licensing and Appointment

23-64-202. General qualifications for licensure — Exemptions.

(a) For the protection of the people of this state, the Insurance Commissioner shall not, at or before completion of application processing, issue, continue, or permit to exist any license as to insurance unless the licensee is in compliance with this chapter and other applicable laws of this state, and as to any individual who does not also meet the following qualifications:

(1) To obtain a license as an agent or broker, he or she shall have complied with the Producer Licensing Model Act, § 23-64-501 et seq., and subsection (b) of this section; and

(2) To obtain a license as an adjuster or insurance consultant, he or she must be:

(A) Of legal age of majority or must have had disabilities of minority removed for all general purposes and provide evidence of same;

(B)(i) A resident of this state or of a city or town through which passes the boundary of this state, qualified as to residence under § 23-64-102(2)(B) and must have been a resident for not less than the thirty (30) days immediately prior to the date of application for the license.

(ii) However, upon written request by the applicant, the commissioner in his or her discretion may waive the thirty-day residence requirement as to any applicant for license who is a bona fide resident of this state and who furnishes proof satisfactory to the commissioner that he or she is and intends to be a permanent resident of Arkansas; and

(C)(i) Deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation, and these qualifications must continue in order to remain licensed.

(ii) On a case-by-case basis, the commissioner may require documentation to verify qualifications for licensure under this section.

(b) All applicants for a license as an agent, broker, adjuster, or insurance consultant shall:

(1) Pass a written examination for the license if required under this chapter and attest that he or she is familiar with the insurance laws of this state and will keep himself or herself familiar despite changes in the law; and

(2)(A)(i) Before licensure or examination, if examination is required, complete specific courses of instruction in the field of insurance as the commissioner shall by regulation prescribe for the license.

(ii) Proof of completion must be presented before testing is administered.

(iii)*(a)* The courses of instruction shall consist, in the aggregate, of not less than twenty (20) hours of classroom instruction or electronic instruction per line of insurance authority. However, an applicant shall not be required to repeat the hours of instruction on Arkansas laws and rules within two (2) years of taking those hours for a previous line of authority.

(b) All instruction shall be administered by or under the supervision of persons qualifying with and approved by the commissioner for that purpose.

(c) An instructor deemed qualified and approved by the commissioner shall monitor attendance and participation and shall sign a certificate evidencing the licensee's completion of the hours.

(d) Applicants for adjuster and consultant licenses are exempt from prelicensing education, as are nonresident applicants for producer licenses from states that engage in reciprocal licensing with Arkansas.

(iv) Successful completion of the courses of instruction shall be certified to the commissioner, on forms prescribed by him or her, by the person under whose supervision the instruction was administered.

(v) The courses of instruction shall provide the applicant with basic knowledge of the broad principles of insurance, licensing, and regulatory laws of this state, and the obligations and duties of an agent, broker, or consultant.

(vi) Programs of instruction may be provided by any authorized insurer, agents' association, or trade association recognized by the commissioner or by any university, college, or any other institution in this state having a comprehensive course of instruction approved and certified by the commissioner.

(vii) The commissioner shall issue appropriate regulations to implement the educational requirements and standards prescribed in this subdivision (b)(2) and to prescribe the general curriculum of courses of instruction.

(viii) The curriculum shall include not less than five (5) hours of instruction relative to the licensing of agents and insurance regulatory laws of this state, criteria for approval of the providers of the courses of instruction, and certifications contemplated hereunder.

(B) None of the provisions of this subsection shall apply to and no examination or educational requirements contained in this subsection shall be required of any applicant for a license presently exempted by law from an examination.

(C) The provisions of subdivision (b)(2)(A) of this section shall not apply to persons making application for license as an agent or broker for crop hail insurance, mobile home physical damage insurance, mortgagor's decreasing term life and disability insurance, prepaid legal insurance, and fire and marine insurance written in connection with credit transactions, or any line exempted by law, for which only a limited license is issued, nor any other insurance for which only a limited license may be issued and the commissioner, by order or regulation, exempts from the educational requirements of subdivision (b)(2)(A) of this section.

(c) No written examination shall be required for:

(1) Any applicant for a license as a limited line credit insurance producer as defined in § 23-64-502;

(2) Automobile dealers or automobile finance companies or their employees applying for licenses covering auto physical damage or the vendor's single interest on motor vehicles only;

(3) Limited lines travel insurance producers and their travel retailers;

(4) Applicants for licenses as nonresident agents or nonresident brokers, but subject to reciprocal arrangements as provided for in this chapter;

(5) Any applicant for a temporary license under this chapter;

(6) Applicants for licenses to sell credit property insurance;

(7)(A) Applicants for licenses to sell funeral expense insurance exclusively.

(B) "Funeral expense insurance" shall be defined in rules adopted by the commissioner;

(8) Applicants for licenses to sell mortgagor's decreasing term life insurance or mortgagor's decreasing term disability insurance to debtors of the applicants or of their employers; or

(9) Applicants for licenses to sell for farmers' mutual aid associations.

(d)(1) The commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance in connection with the rental of vehicles.

(2) As used in this subsection:

(A) "Limited license" means the authority of a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection;

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease;

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed ninety (90) days;

(D) "Rental period" means the term of the rental agreement;

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed ninety (90) days; and

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles and of the cargo type, including cargo vans, pickup trucks, and trucks with a gross vehicle weight of less than twenty-six thousand pounds (26,000 lbs.) and that do not require the operator to possess a commercial driver's license.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the commissioner a written application for a limited license signed by an officer of the applicant, in such form or forms and supplements thereto, and containing such information as the commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the commissioner may:

(A) After notice and hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of law; or

(B) After notice and hearing, impose other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to this subsection may offer or sell insurance underwritten by a licensed insurer or authorized surplus lines carrier only in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection coverage in a master, corporate, group rental, or individual agreement in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance that at the exclusive option of the rental company may include uninsured and underinsured motorist coverage whether offered separately or in combination with other liability insurance that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other vehicle occupants for the loss of or damage to personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or auto-related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance may be issued by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed ninety (90) consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that the coverage offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(C) Evidence of coverage is disclosed within the rental agreement provided to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf of and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall conduct a training program in which employees being trained shall receive basic instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverages shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(e)(1) As used in this section:

(A) "Limited lines travel insurance producer" means a licensed insurance producer or agent designated as the travel insurance supervising entity under subdivision (e)(8) of this section;

(B) "Offer and disseminate" means to:

(i) Provide general information, including without limitation a description of the insurance coverage and the cost of the insurance coverage;

(ii) Process an application for insurance coverage;

(iii) Collect the premiums for insurance coverage; and

(iv) Perform other nonlicensed activities allowed by the insurance laws of this state;

(C)(i) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including without limitation:

(a) Interruption or cancellation of a trip or event;

(b) Loss of baggage or personal effects;

(c) Damages to accommodations or rental vehicles; and

(d) Sickness, accident, disability, or death occurring during travel.

(ii) "Travel insurance" does not include major medical plans that provide comprehensive medical protection for travelers on trips of six (6) months or more, including without limitation working overseas and deployment of military personnel; and

(D) "Travel retailer" means a business entity that makes, arranges, and offers travel services and offers travel insurance as a service to its customers on behalf of a limited lines travel insurance producer.

(2) The commissioner may issue to a limited lines travel insurance producer in compliance with this section a limited license to offer or sell travel insurance.

(3) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer license if the limited lines travel insurance producer:

(A) Provides a purchaser with the material terms of the insurance coverage or a description of the material terms, a description of the process for filing a claim, the review or cancellation process for the travel insurance policy, and the identity of and contact information for the insurer and limited lines travel insurance producer;

(B)(i) Establishes at the time of licensure and maintains a register on a form prescribed by the commissioner of each travel retailer that offers travel insurance on behalf of the limited lines travel insurance producer.

(ii) The register shall include:

(a) The identity of and contact information for the travel retailer and an officer or other person who directs or controls the travel retailer's operations; and

(b) The federal employer identification number of the travel retailer;

(C)(i) Provides on application for and renewal of a limited lines travel insurance producer license a list of each travel retailer that offers travel insurance on its behalf.

(ii) The limited lines travel insurance producer shall certify that the travel retailer is in compliance with 18 U.S.C. § 1033, as it existed on January 1, 2013;

(D) Designates an employee who is a licensed individual producer to be responsible for compliance issues;

(E) Pays the applicable insurance producer licensing fees; and

(F)(i) Requires each employee of the travel retailer that offers and disseminates travel insurance to receive instruction or training that may be reviewed by the commissioner.

(ii) At a minimum, the training material shall contain instructions on the types of insurance offered, ethical sales practices, and the required disclosures to provide to customers.

(4) In a brochure or other written materials, a travel retailer shall make available to customers the following information:

(A) The identity of and contact information for the insurer and limited lines travel insurance producer;

(B) An explanation that the purchase of travel insurance is not required to purchase any other product or service from the travel retailer; and

(C) An explanation that an unlicensed travel retailer may provide general information about the insurance coverage offered by the travel retailer, including a description of the insurance coverage and the cost of the insurance coverage, but shall not answer technical questions about the insurance terms offered by the travel retailer or provide an evaluation of the adequacy of any existing insurance coverage.

(5) A travel retailer that is not licensed as an insurance producer shall not:

(A) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(B) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(C) Hold itself out as a licensed insurer, producer, or insurance expert.

(6) A travel retailer and its employees that receive training under subdivision (e)(3)(F) of this section and whose insurance-related activities are limited to offering and disseminating travel insurance on behalf of a limited lines travel insurance producer that is licensed under this subchapter may receive compensation if listed on the registry maintained by the limited lines travel insurance producer under subdivision (e)(3)(B) of this section.

(7) Travel insurance may be provided under an individual policy, a group policy, or a master policy.

(8) As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this section.

(9) The limited lines travel insurance producer and a travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer license are subject to the Trade Practices Act, § 23-66-201 et seq., and the licensing requirements of the Producer Licensing Model Act, § 23-64-501 et seq.

History. Acts 1959, No. 148, § 153; 1975, No. 547, § 1; 1983, No. 522, §§ 10, 11; 1983, No. 534, §§ 1, 4, 5; A.S.A. 1947, §§ 66-2810, 66-2811.2, 66-2811.3; Acts 1987, No. 927, § 2; 1993, No. 523, § 1; 1993, No. 901, §§ 14-16; 1995, No. 592, § 1; 1997, No. 1004, § 1; 2001, No. 580, § 6; 2003, No. 1203, § 2; 2005, No. 1948, § 1; 2013, No. 1494, §§ 1, 2.

Amendments. The 2013 amendment rewrote (c)(3); and added (e).

23-64-209. Qualifications for adjuster's license.

(a) No person shall, in this state, act as or hold himself or herself out to be an adjuster unless then licensed therefor under this chapter. Application for license shall be made to the Insurance Commissioner according to forms as prescribed and furnished by him or her. The commissioner shall issue the adjuster's license for property insurance, or for casualty insurance, or for workers' compensation insurance, or for any combination thereof as to individuals qualified therefor upon payment of the nonrefundable license fee stated in § 23-61-401.

(b) To be licensed as an adjuster, the applicant must be qualified as follows:

(1) Must be of the legal age of majority, or have had the disabilities of minority removed for all general purposes and provide evidence of same;

(2)(A) Must be a resident of this state or licensed by another state that permits residents of this state to act as adjusters in the other state.

(B) A resident of another state or foreign country shall not be licensed as a nonresident independent adjuster in this state unless the person is licensed as an adjuster in another state;

(3) Must be a full-time salaried employee of a licensed adjuster, or a graduate of a recognized law school, or must have had experience or special education or training as to the handling of property, casualty, or workers' compensation loss claims under insurance contracts of sufficient duration and extent reasonably to make him or her competent to fulfill the responsibilities of an adjuster;

(4) Must be deemed by the commissioner to be competent, trustworthy, financially responsible, and of good personal and business reputation;

(5) Must have and maintain in this state an office accessible to the public and keep therein the usual and customary records pertaining to transactions under the license. This provision shall not be deemed to prohibit maintenance of an office in the home of the licensee. A licensed, nonresident adjuster shall not be required to maintain an office in this state;

(6)(A)(i) Must pass a written examination as to his or her competence to act as a property, casualty, or workers' compensation insurance adjuster as shall be required by the commissioner.

(ii) The commissioner may give, conduct, and grade all examinations or he or she may arrange to have examinations administered and graded by an independent testing service as specified by contract,

in a fair and impartial manner, and without unfair discrimination as between individuals examined.

(iii) The commissioner may require a waiting period of four (4) weeks before reexamination of an applicant who thrice failed to pass previous similar examinations. This waiting period applies after every third unsuccessful attempt.

(iv) The nonrefundable application fee shall be the same as that charged an applicant for license as an agent or broker under § 23-61-401.

(B)(i) If the application is approved and if the nonrefundable application fee is paid, an examination permit will be issued to the applicant.

(ii) The permit will be valid for a period of ninety (90) days from the date of issuance.

(iii) If the applicant does not schedule and appear for examination within that ninety-day period, the permit shall expire and the applicant may be required to file a new application and shall pay another nonrefundable application fee before issuance of another examination permit to the applicant.

(iv) If the applicant appears for examination but fails to pass such an examination, the applicant shall be required to pay a nonrefundable reexamination fee before reexamination.

(C) By reciprocal arrangements with the insurance supervisory official in the other state, the commissioner may waive written examination of a nonresident applicant for license as an adjuster, if the official certifies that the applicant is licensed as a resident adjuster of that state and has complied with its qualification standards therefor.

(c) A firm, limited liability company, or corporation, whether or not organized under the laws of this state, may be licensed as an adjuster if each individual who is to exercise the license powers is named in the license and is qualified as for an individual licensed as adjuster. An additional full license fee shall be paid as to each individual in excess of one (1), so named in the license to exercise its powers.

(d) An adjuster who is sent into this state on behalf of an insurer for the purpose of investigating or making adjustment of a loss resulting from a catastrophe under an insurance policy is not required to be qualified or licensed under this section if within ten (10) business days of entering the state the adjuster notifies the commissioner in writing of the adjuster's activities on behalf of the insurer.

(e)(1)(A) Unless exempt under subdivision (e)(2) of this section, a licensed adjuster shall successfully complete and report a minimum of twenty-four (24) hours of continuing education courses approved by the commissioner within the time established by rule of the commissioner.

(B) At least three (3) hours of continuing education required by this subsection shall be in an ethics course approved by the commissioner.

(2) This subsection does not apply to an adjuster licensed in:

(A) This state for less than one (1) year; or

(B) Another state if the adjuster has satisfied the continuing education requirements of the licensing state.

History. Acts 1959, No. 148, § 176; 1983, No. 522, § 21; 1985, No. 804, § 20; A.S.A. 1947, § 66-2833; Acts 1987, No. 622, §§ 15-17; 1997, No. 1004, § 1; 1999, No. 657, §§ 4, 5; 2009, No. 726, §§ 25-27; 2013, No. 754, § 2.

Amendments. The 2013 amendment in (b)(2), added the (A) designation, inserted "or licensed by," substituted "this state" for "Arkansas," and added (B).

23-64-233. Limited license for self-service storage insurance.

(a) As used in this section:

(1) "Customer" means an individual or entity that obtains the use of a storage space from a self-service storage facility under the terms of a self-service storage rental agreement;

(2) "Insured customer" means a customer that purchases insurance under a self-service storage insurance policy that is sold, solicited, or negotiated by a self-service storage facility;

(3) "Limited licensee" means an owner authorized by this section to sell certain coverages relating to the rental of space within a self-service storage facility;

(4)(A) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility.

(B) "Owner" includes an owner's agent and any other person authorized by the owner to manage the self-service storage facility or to receive rent from a customer under a rental agreement;

(5) "Personal property" means movable property not affixed to land and includes without limitation goods, wares, merchandise, household items, and vehicles;

(6) "Rental agreement" means a written agreement or lease that establishes or modifies the terms, conditions, rules, or other provisions concerning the use and occupancy of a self-service storage facility;

(7)(A) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing storage space to customers that are given access to the storage space to store and remove personal property.

(B) "Self-service storage facility" does not include storage space that is used for residential purposes;

(8)(A) "Self-service storage insurance" means insurance that provides coverage for personal property stored at a self-service storage facility during the term of an insured customer's rental agreement against any one (1) or more of the following causes:

(i) Loss;

(ii) Theft;

(iii) Damage; or

(iv) Other loss directly related to the rental of the self-service storage space.

(B) "Self-service storage insurance" does not include:

(i) Homeowners or renters insurance; or

(ii) Private passenger automobile, commercial multi-peril, or similar insurance; and

(9) "Supervising entity" means a business entity that is an insurer or insurance producer licensed under the insurance laws of this state.

(b) The Insurance Commissioner may issue to a self-service storage facility that has complied with the requirements of this section a limited license authorizing the limited licensee to offer or sell insurance in connection with the rental of self-service storage facilities and the corresponding rental agreements.

(c) A self-service storage facility shall not sell or offer insurance in connection with the rental of storage space unless the owner has procured a limited license from the commissioner.

(d) The commissioner may issue a limited license to an owner upon written application by the owner, without examination, on a form prescribed by the commissioner.

(e) If this section is violated by a limited licensee or by the limited licensee's employee or authorized representative, the commissioner after notice and a hearing may impose:

(1) A fine not to exceed five hundred dollars ($500) for each violation or five thousand dollars ($5,000) in the aggregate; and

(2) Other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this section, including without limitation:

(A) Suspending the privilege of transacting self-service storage insurance under this section at a specific self-service storage facility where a violation has occurred; and

(B) Suspending or revoking the ability of an individual employee or authorized representative of the owner to act under the owner's limited license.

(f) A limited licensee is authorized to offer or sell coverage under a policy of self-service storage insurance on behalf of a licensed insurer only:

(1) In connection with a rental agreement;

(2) As an individual policy issued to an individual customer for personal property insurance;

(3) For policy forms and rates that have been filed in compliance with § 23-67-201 et seq. and § 23-79-101 et seq.; and

(4)(A) When brochures or other written materials have been filed with the commissioner in compliance with § 23-79-101 et seq. and are made readily available to each prospective customer.

(B) The brochures or other written materials shall:

(i) Disclose that self-service storage insurance may duplicate coverage already provided under a customer's homeowners insurance policy, renters insurance policy, or other coverage;

(ii) State that the purchase by the customer of self-service storage insurance is not required in order to lease self-service storage space;

(iii) Clearly and correctly summarize the material terms of each self-service storage insurance policy offered to customers, including without limitation:

(a) The identity of the insurer;

(b) The identity of the supervising entity;

(c) The amount of any applicable deductible and how it is to be paid;

(d) The benefits of the coverage; and

(e) The key terms and conditions of coverage, including without limitation whether covered property may be repaired or replaced;

(iv) Summarize the process for filing a claim;

(v) State that the insured customer may cancel coverage under the self-service storage insurance policy at any time, and the person paying the premium will receive a refund of any unearned premium;

(vi) Disclose that a limited licensee or the employee of the limited licensee may not evaluate or provide advice concerning a prospective occupant's existing insurance coverage; and

(vii) State that the self-service storage facility limited licensee or the employee of the limited licensee is not and may not claim to be a licensed nonlimited lines insurance producer or an insurance expert.

(g) Evidence of self-service storage insurance coverage and its terms and conditions shall be disclosed within the rental agreement and provided to every customer who elects to purchase self-service storage insurance coverage.

(h) A limited license authorizes an employee or an authorized representative of the limited licensee to act individually on behalf of and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subchapter if the employee or authorized representative of the employee does not:

(1) Evaluate or provide advice concerning a prospective customer's existing insurance coverage;

(2) Claim to be a licensed nonlimited lines insurance producer or an insurance expert; or

(3)(A) Obtain compensation based primarily on the numbers of customers enrolled for self-service storage insurance coverage.

(B) However, the employee or authorized representative of the employee may receive compensation for activities under the limited lines license which is incidental to overall compensation.

(i)(1) A limited licensee shall conduct a training program for each employee and authorized representative of an employee that offer self-service storage insurance.

(2) The training program shall include basic instruction about the kinds of coverage specified in this section and offered for purchase by prospective customers of self-service storage facilities.

(j)(1) Charges for self-service storage insurance may be billed and collected by the self-service storage facility.

(2) If the insurance cost is not included in the fees associated with the self-service storage rental agreement, the insurance cost shall be separately itemized on the insured customer's bill.

(3) If the insurance cost is included in the fee associated with a self-service storage rental agreement, the self-service storage facility shall clearly and conspicuously disclose within the rental agreement the price of the self-service storage insurance coverage.

(4) A self-service storage facility that bills and collects the charges for self-service storage insurance shall not be required to maintain the funds in a segregated account if the owner:

(A) Is authorized by the insurer to hold the funds in an alternative manner; and

(B) Remits the funds to the supervising entity within sixty (60) days of receipt of the funds.

(5) Funds received from an insured customer for the sale of self-service storage insurance shall be held in trust by the owner in a fiduciary capacity for the benefit of the insurer.

(6) Owners may receive compensation from the insurer for billing and collecting self-service storage insurance.

History. Acts 2013, No. 588, § 1.

Subchapter 3 — Continuing Education

SECTION.

23-64-301. Continuing education required.

(a)(1) Unless exempt under § 23-64-302, an insurance producer licensed in this state shall successfully complete and report the courses of instruction required by this section within the biennial period prescribed by rule of the Insurance Commissioner for the insurance producer to satisfy the continuing education requirements necessary to continue the insurance producer's license.

(2) The exemptions in § 23-64-302(3) and (4) do not apply to an insurance producer licensed after July 1, 2003.

(3) A resident insurance producer who qualified for an exemption under § 23-64-302(3) or (4) and then moved to another state may maintain the exemption when the insurance producer returns to this state if upon application to the commissioner for a reinstatement of the exemption the insurance producer has been continuously licensed in this state as a resident or nonresident insurance producer from the time he or she first qualified for the exemption.

(b) An individual who holds a title insurance license shall complete the minimum number of hours of continuing education courses established by rule of the commissioner.

(c) The commissioner may promulgate rules containing the continuing education requirements for insurance producers licensed in this state as necessary for continued uniformity among the states.

(d) The commissioner may hire an independent contractor to administer all or part of this subchapter in a fair and impartial manner.

History. Acts 1989, No. 445, § 1; 1997, No. 1004, § 1; 2001, No. 1603, § 20; 2003, No. 1784, § 1; 2007, No. 684, § 4; 2009, No. 726, § 31; 2011, No. 760, § 7; 2013, No. 534, § 1.

Amendments. The 2013 amendment added (a)(3).

Subchapter 6 — Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act [Contingent effective date.]

SECTION.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-601. Title. [Contingent effective date.]

This subchapter shall be known and may be cited as the "Arkansas Health Insurance Marketplace Navigator, Guide, and Certified Application Counselors Act".

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued

under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-602. Definitions. [Contingent effective date.]

As used in this subchapter:

(1) "Applicant" means a person who has applied to become licensed under this subchapter as a navigator, guide, certified application counselor, or certified licensed producer;

(2) "Certified application counselor" means a person who is licensed under this subchapter to assist in enrolling consumers in a variety of marketplace-designated organizations settings, including without limitation a healthcare facility, but is not compensated by federal marketplace funds;

(3) "Certified licensed producer" means a person who is:

(A) Licensed as an insurance producer as defined in § 23-64-502;

(B) Certified under this subchapter to:

(i) Educate consumers about health insurance marketplaces, Medicaid, tax credits, and other cost-sharing reductions; and

(ii) Assist consumers with enrollment in a health insurance marketplace;

(C) Eligible to receive commissions from health insurers; and

(D) Not compensated under the federal act, federal regulations, or any guidance issued under the federal act or federal regulations;

(4) "Consumer" means an individual, family, or small business located in this state;

(5) "Enrollment" means enrolling in a qualified health plan offered through a health insurance marketplace;

(6) "Federal act" means the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments to or regulations or guidance issued under those statutes existing on the effective date of this act;

(7) "Guide" means a person who is licensed under this subchapter to provide in-person assistance and services as stated in 45 C.F.R. § 155.210;

(8)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(B) "Health benefit plan" does not include:

(i) Coverage only for accident or disability income insurance, or both;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including without limitation general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are secondary or incidental to other insurance benefits.

(C) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or a combination of these; or

(iii) Other similar limited benefits specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act.

(D) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act, Pub. L. No. 74-271, as existing on the effective date of this act;

(ii) Coverage supplemental to the coverage provided to military personnel and their dependents under Chapter 55 of Title 10 of the United States Code and the Civilian Health and Medical Program of the Uniformed Services, 32 C.F.R. Part 199; or

(iii) Similar supplemental coverage provided to coverage under a group health plan;

(9) "Health insurance" means insurance that is primarily for the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure of the body, including transportation that is essential to obtaining health insurance, but excluding:

(A) Coverage only for accident or disability income insurance, or any combination thereof;

(B) Coverage issued as a supplement to liability insurance;

(C) Liability insurance, including general liability insurance and automobile liability insurance;

(D) Workers' compensation or similar insurance;

(E) Automobile medical payment insurance;

(F) Credit-only insurance;

(G) Coverage for on-site medical clinics;

(H) Coverage only for limited scope vision benefits;

(I) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(J) Coverage for specified disease or critical illness;

(K) Hospital indemnity or other fixed indemnity insurance;

(L) Medicare supplement policies;

(M) Medicare, Medicaid, or the Federal Employee Health Benefit Program, 5 U.S.C. §§ 8901 — 8914, as it existed on January 1, 2013;

(N) Coverage only for medical and surgical outpatient benefits;

(O) Excess or stop-loss insurance; and

(P) Other similar insurance coverage:

(i) Under which benefits for health insurance are secondary or incidental to other insurance benefits; or

(ii) Specified in federal regulations issued under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, and existing on the effective date of this act, under which benefits for healthcare services are secondary or incidental to other insurance benefits;

(10) "Health insurance marketplace" means the vehicle created to help consumers in this state shop for and select health insurance coverage in a way that permits comparison of available qualified health plans based on price, benefits, services, and quality, regardless of its governance structure;

(11) "Health insurer" means an entity that provides health insurance or a health benefit plan in this state, including without limitation an insurance company, medical services plan, hospital plan, hospital medical service corporation, health maintenance organization, fraternal benefits society, or any other entity providing a plan of health insurance or health benefits in this state, and is subject to state insurance regulation;

(12) "License" means a document issued by the Insurance Commissioner authorizing a person to act as a navigator, guide, certified application counselor, or certified licensed producer;

(13) "Licensee" means a navigator, guide, certified application counselor, or certified licensed producer who is licensed under this subchapter;

(14) "Navigator" means a person authorized under the federal act to assist consumers to shop for and select health insurance offered through a health insurance marketplace, including providing information to a consumer on a health benefit plan or coverage offered through a health insurance marketplace, or facilitates enrollment in a health insurance marketplace;

(15) "Non-navigator assistance personnel" means a person authorized under the federal act to assist consumers to enroll and understand the health insurance offered through a health insurance marketplace;

(16) "Person" means an individual, company, firm, organization, association, corporation, government entity, nongovernmental entity, or any other type of legal entity; and

(17) "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the federal act.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-603. Navigator license required. [Contingent effective date.]

(a)(1) A person shall not act as a navigator in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A grant awarded under a navigator contract is contingent on a person's:

(1) Being licensed under this subchapter;

(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or

(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.

(c) A navigator shall:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 as existing on the effective date of this act and cost-sharing reductions under section 1402 of the federal act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman or to any other appropriate state agency or agencies for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage; and

(5) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under

section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013.

(d) A navigator shall not advise a person to select a particular plan.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-604. Guide license required. [Contingent effective date.]

(a)(1) A person shall not act as a guide in this state through a health insurance marketplace unless licensed under this subchapter as an eligible entity.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A contract awarded to a guide is contingent on a person's:

(1) Being licensed under this subchapter;

(2) Becoming licensed under this subchapter by September 30, 2013, or within ninety (90) days after the receipt of funding; or

(3) Employing a licensee that meets the requirements in subdivision (b)(1) or subdivision (b)(2) of this section.

(c) A guide shall:

(1) Assist consumers in understanding the available qualified health plans offered through a health insurance marketplace, their differences, premium tax credits, cost-sharing provisions, and the public programs and their eligibility;

(2) Provide enrollment information in a culturally and linguistically appropriate manner that meets the needs of the population being served by a health insurance marketplace in this state, including those individuals with limited English proficiency or who are protected under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131-12165, as they existed on January 1, 2013;

(3) Ensure that information is provided in a way that simplifies choices and considers the individual needs of consumers;

(4) Maintain expertise in eligibility, enrollment, and public and private insurance specifications and conduct public education activities to raise awareness about the health insurance marketplace in this state;

(5) Provide information and services in a fair, accurate, and impartial manner that acknowledges other health programs;

(6) Increase awareness of insurance options in a way that does not stigmatize qualified health plans;

(7) Facilitate enrollment in qualified health plans or coverage offered through a health insurance marketplace and with post-enrollment dispute resolution;

(8) Provide referrals to an applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg et seq., as it existed on January 1, 2013, or any other appropriate state agency or agencies, for a consumer participating in enrollment with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under the plan or coverage;

(9) Not receive any financial consideration directly or indirectly from a health insurer or stop-loss insurance company or qualified health plan;

(10) Demonstrate that no conflict of interest exists in providing in-person assistance and the services as stated in 45 C.F.R. § 155.210; and

(11) Provide resources or avenues for consumers to register complaints and grievances with a service provided through the health insurance marketplace.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-605. Certified application counselor license required. [Contingent effective date.]

(a)(1) A person shall not act as a certified application counselor in this state through a health insurance marketplace unless licensed under this subchapter and working for a marketplace-designated organization.

(2) A health insurer or an affiliate of a health insurer is not an eligible entity.

(b) A certified application counselor shall assist in enrolling a consumer in a qualified health plan through a health insurance marketplace.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is

initiated and is operable in this state."

23-64-606. Licensed producer — Certification required. [Contingent effective date.]

A person shall not act as a certified licensed producer in this state through a health insurance marketplace unless certified under this subchapter.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-607. Qualifications for licensure or certification — Issuance. [Contingent effective date.]

(a) To qualify for a license or certification under this subchapter, a person shall:

(1) Be at least eighteen (18) years of age;

(2) Have received a high school diploma or a general education development certificate;

(3) Be competent, trustworthy, financially responsible, and of good personal and business reputation;

(4) Continue the qualifications under subdivision (a)(3) of this section while licensed or certified;

(5)(A) Pass an examination and satisfy the educational requirements the Insurance Commissioner may impose by rule or order.

(B) The examination required by this section shall be developed and conducted under rules prescribed by the commissioner;

(6)(A) Have received instruction in health insurance, the provisions of the federal act for a health insurance marketplace in this state, and the medical assistance programs of this state.

(B) The instruction required by this section shall be developed and conducted under rules prescribed by the commissioner; and

(7) For a certified licensed producer, be a licensee in good standing under the Producer Licensing Model Act, § 23-64-501 et seq.

(b) In addition to the other information required under this subchapter or rules adopted by the commissioner, an application for a license or certification under this subchapter shall include:

(1) The applicant's business name, address, and social security number or taxpayer identification number;

(2) A criminal and regulatory background check of the applicant; and

(3) A description of the applicant's current business operations and its activities, duties, and responsibilities, including without limitation:

(A) The place of organization and a certified copy of the applicant's organizational and governance documents;

(B) If a foreign business, a copy of the certificate of authority from the Secretary of State;

(C) The proposed method of business operation and, if applicable, other locations for doing business; and

(D)(i) The qualifications, business experience and history, and financial condition of the applicant, its affiliates, and its employees.

(ii) Information required under subdivision (b)(3)(D)(i) of this section shall include:

(a) A description of any injunction or administrative order, including a denial to engage in a regulated activity by a state or federal authority that had jurisdiction over the applicant, its affiliates, and its employees;

(b) A conviction of a misdemeanor involving fraudulent dealings or moral turpitude or relating to any aspect of the insurance industry, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(c) Any felony conviction; and

(d) A beneficial interest in an affiliated industry business.

(c) Each applicant shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.

(d) Each license or certification issued by the commissioner under this subchapter expires at the close of business on September 30 of the calendar year unless otherwise surrendered or revoked.

(e) A license or certification issued under this subchapter is not transferable.

(f) To assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that the National Association of Insurance Commissioners oversees, to perform any ministerial functions that the commissioner and the nongovernmental business may consider appropriate, including the collection of the annual fee for licensure or certification of a navigator, guide, certified application counselor, or certified licensed producer.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-608. License renewal. [Contingent effective date.]

(a) A licensee shall submit an application for renewal of a license or certification issued under this subchapter in a form prescribed by the Insurance Commissioner.

(b) An applicant for a license or certification renewal is required to complete continuing education as prescribed by rule of the commissioner.

(c) Each licensee shall pay a reasonable annual licensure or certification fee as established by rule of the commissioner.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-609. Additional licensee duties. [Contingent effective date.]

(a) A licensee is subject to the insurance laws of this state, including those concerning privacy, market conduct, and unfair trade practices acts.

(b) A licensee shall:

(1) Comply with other consumer protection and market conduct standards that the Insurance Commissioner considers necessary; and

(2) Counsel enrollees in the health insurance marketplace in this state about options in Medicaid, the federal Children's Health Insurance Program, and other health insurance coverage.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-610. Prohibited activities. [Contingent effective date.]

(a) Except for a certified licensed producer, a licensee shall not:

(1) Receive compensation directly or indirectly from any health insurer;

(2) Engage in an activity that requires licensing as a residential insurance producer under the Producer Licensing Model Act, § 23-64-501 et seq.; or

(3) Recommend a particular plan or advise consumers about which plan to choose.

(b) A licensee shall not engage in improper conduct, commit fraud, or violate marketplace and consumer protection requirements of this state.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-611. Disciplinary authority. [Contingent effective date.]

(a) The Insurance Commissioner by order may deny, suspend, revoke, or refuse to issue or renew a license of a licensee or applicant under this subchapter or may restrict or limit the activities of a licensee if the commissioner finds that:

(1) The order is in the public interest; and

(2) A licensee or applicant:

(A) Has filed an application for an initial license or a renewal of a license that as of its effective date or as of any date after the filing of the application, contains an omission or statement that in light of the circumstances under which it was made is false or misleading with respect to any material fact;

(B) Has violated or failed to comply with this subchapter, the insurance laws of this state, any rule adopted by the commissioner, or any order of the commissioner issued under this subchapter;

(C) Has pleaded guilty or nolo contendere to or has been found guilty in a domestic, foreign, or military court of:

(i) A felony;

(ii) An offense involving breach of trust, moral turpitude, money laundering, or fraudulent or dishonest dealing; or

(iii) An offense involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(D) Is permanently or temporarily enjoined by a court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the insurance business, the mortgage industry, the securities industry, or any other activity pertaining to financial services;

(E) Is the subject of an order of the commissioner:

(i) Denying, suspending, revoking, restricting, or limiting a license issued under the insurance laws of this state; or

(ii) Directing the licensee or applicant to cease and desist an activity regulated by the commissioner;

(F) Is the subject of an order, including a denial, suspension, or revocation of authority to engage in a regulated activity by another state or federal authority to which the licensee or applicant is, has been, or has sought to be subject, entered in the past five (5) years, including without limitation the insurance industry;

(G)(i) Has failed to pay the proper fees as established by rule of the commissioner.

(ii) The commissioner may enter a denial order against a licensee or applicant under subdivision (a)(2)(G)(i) of this section if the licensee or applicant fails to pay the proper fees as established by rule of the commissioner, but the denial order shall be vacated by the commissioner if the fees are paid;

(H) Has engaged in fraudulent, coercive, or dishonest practices or demonstrated incompetence, untrustworthiness, lack of good personal or business reputation, or financial irresponsibility;

(I) Has forged another's name to an application for insurance or to any document related to an insurance transaction;

(J) Has improperly used notes or any other reference material to complete an examination for an insurance license;

(K) Has failed to provide a written response within thirty (30) days after receipt of a written inquiry from the commissioner or the commissioner's designee concerning transactions unless the commissioner waives the requirement of a timely response in writing;

(L) Has failed to comply with an administrative or court order imposing a child support obligation;

(M) Has failed to pay state income tax or comply with an administrative or court order directing payment of state income tax;

(N) Has refused to be examined or to produce an account, record, or file for examination at the request of the commissioner or the commissioner's designee; or

(O) Has failed to cooperate with the commissioner in an investigation.

(b) The commissioner by order may:

(1)(A) Impose a civil penalty on a licensee for a violation of this subchapter, the insurance laws of this state, a rule under this subchapter, or an order of the commissioner.

(B) The civil penalty shall not exceed ten thousand dollars ($10,000) for each violation under subdivision (b)(1)(A) of this section by a licensee;

(2) Summarily postpone or suspend the license of a licensee pending a final determination of a proceeding under this section; and

(3) Change or vacate an order or extend it until a final determination of a preceeding under this section if a hearing is requested or ordered by the commissioner.

(c) On entering an order under subdivision (b)(1) or subdivision (b)(2) of this section, the commissioner shall:

(1) Promptly notify the licensee by sending notice of the order and the reasons for issuing the order to the address of the licensee on file with the commissioner by first class mail, postage prepaid; and

(2)(A) Schedule a hearing under § 23-61-301 et seq. if a licensee contests the order.

(B) The licensee may contest an order entered under subdivision (b)(1) or subdivision (b)(2) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.

(C)(i) The hearing shall be held within thirty (30) days after the commissioner receives a timely written request for a hearing.

(ii) At the request of the licensee, the hearing may be postponed for a reasonable amount of time.

(D) If a licensee does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until the order is modified or vacated by the commissioner.

(d) The commissioner by order may cancel a license or application if the commissioner finds that a licensee or applicant:

(1) Is no longer in existence;

(2) Has stopped doing business as a licensee;

(3) Is subject to an adjudication of mental incompetence or to the control of a committee, conservator, or guardian; or

(4) Cannot be located after a reasonable search by the commissioner.

(e)(1) In addition to other powers under this subchapter, on finding that an action of a person is in violation of this subchapter, the commissioner may summarily order the person to cease and desist the prohibited action.

(2) On entering the order under subdivision (e)(1) of this section, the commissioner shall:

(A) Promptly notify the person by sending notice of the order and the reasons for issuing the order to the last known address of the person by first class mail, postage prepaid; and

(B)(i) Schedule a hearing under § 23-61-301 et seq. if the person contests the order.

(ii) The person may contest an order entered under subdivision (e)(1) of this section by delivering a written request for a hearing to the commissioner within thirty (30) days after the date on which notice of the order is sent by the commissioner.

(iii)*(a)* The hearing shall be held within thirty (30) days after the commissioner receives a timely written request for a hearing.

(b) At the request of the person, the hearing may be postponed for a reasonable amount of time.

(iv) If a person does not request a hearing and the commissioner does not order a hearing, the order shall remain in effect until it is modified or vacated by the commissioner.

(3)(A) A person is subject to a civil penalty of up to twenty-five thousand dollars ($25,000) for each violation of the commissioner's cease and desist order committed after entry of the order if:

(i) The person under the cease and desist order fails to appeal the order under § 23-61-307 or if the person appeals and the appeal is denied or dismissed; and

(ii) The person continues to engage in the prohibited action in violation of the commissioner's order.

(B) The commissioner may file an action requesting the civil penalty under subdivision (e)(3)(A) of this section with the Pulaski County Circuit Court or another court of competent jurisdiction.

(C) The penalties of this section apply in addition to, but not instead of, other applicable law to a person for the person's failure to comply with an order of the commissioner.

(f) Unless otherwise provided, an action, hearing, or other proceeding under this subchapter is governed by § 23-61-301 et seq.

(g) If the commissioner has grounds to believe that a licensee has violated this subchapter or that facts exist that would be the basis for an order against a licensee, the commissioner or the commissioner's designee may investigate or examine the business of the licensee and examine the books, accounts, records, and files of a licensee relating to the complaint or matter under investigation.

(h)(1) The commissioner or the commissioner's designee may:

(A) Administer oaths and affirmations;

(B) Issue subpoenas to require the attendance of and to take testimony of a person whose testimony the commissioner considers relevant to the licensee's business; and

(C) Issue subpoenas to require the production of the books, papers, correspondence, memoranda, agreements, or other documents or records that the commissioner considers relevant or material to the inquiry.

(2)(A) When there is contumacy by or refusal to obey a subpoena issued to a licensee or applicant, the Pulaski County Circuit Court, on application by the commissioner, may issue an order requiring the person to appear before the commissioner or the commissioner's designee to produce evidence if so ordered or to give evidence touching the matter under investigation or in question.

(B) Failure to obey the order of the court may be punished by the court as a contempt of court.

(3) The assertion that the testimony or evidence before the commissioner may tend to incriminate or subject a person to a penalty or forfeiture shall not under § 23-61-302 excuse the person from:

(A) Attending and testifying;

(B) Producing any document or record; or

(C) Obeying the subpoena of the commissioner or the commissioner's designee.

(i) From time to time and with or without cause, the commissioner may conduct examinations of the books and records of a licensee or applicant to determine the compliance with this subchapter and the rules adopted under this subchapter.

(j) This section does not prohibit or restrict the informal disposition of a proceeding or allegations that may give rise to a proceeding by stipulation, settlement, consent, or default instead of a formal or informal hearing on the allegations or in place of the sanctions authorized by this section.

(k)(1) If it appears on sufficient grounds or evidence satisfactory to the commissioner that a person has engaged in or is about to engage in an act or practice that violates this subchapter, the commissioner may:

(A) Refer the evidence that is available concerning violations of this subchapter or a rule or order issued under this subchapter to the prosecuting attorney or regulatory agency that with or without the referral may otherwise begin criminal or regulatory proceedings under this subchapter; and

(B)(i) Summarily order the person to stop the act or practice under subsections (b) and (e) of this section and apply to the Pulaski County Circuit Court to enjoin the act or practice or to enforce compliance with this subchapter, rule, or order issued under this subchapter, or both.

(ii) The commissioner, without issuing a cease and desist order, may apply directly to the Pulaski County Circuit Court for injunctive or other relief.

(2) On proper showing, the court shall grant a permanent or temporary injunction, restraining order, or writ of mandamus.

(3) The commissioner may also seek and on proper showing the appropriate court shall grant any other ancillary relief that may be in the public interest, including:

(A) The appointment of a receiver, temporary receiver, or conservator;

(B) A declaratory judgment;

(C) An accounting;

(D) Disgorgement;

(E) Assessment of a fine of not more than ten thousand dollars ($10,000) for each violation; and

(F) Any other relief as may be appropriate in the public interest.

(4) The court shall not require the commissioner to post a bond.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-612. Authority — Grants and contracts. [Contingent effective date.]

(a) The health insurance marketplace in this state may accept grants or contract with a governmental or nongovernmental entity that uses navigators or guides on the conditions the health insurance marketplace finds to be in the best interest of the citizens of this state if the governmental or nongovernmental entity:

(1) Has a physical business location to conduct business with this state and its service area;

(2) Is considered to be competent, trustworthy, financially responsible, and of a good business reputation;

(3) Continues the qualifications under subdivision (a)(2) of this section during the contract;

(4) Requires the members of management of the governmental or nongovernmental entity to complete instruction in health benefit plans or health insurance, the provisions of the federal act for a health insurance marketplace in this state, and the medical assistance programs of this state through a training program approved by the Insurance Commissioner for the required minimum hours; and

(5) Furnishes to the commissioner information concerning the identity and background of the members of management of the governmental or nongovernmental entity, including criminal and regulatory background checks.

(b) Each nongovernmental business entity shall pay a reasonable annual licensure fee that is established by rule.

(c) A grant or contract under this section is not transferable.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-613. Rules. [Contingent effective date.]

(a) The Insurance Commissioner may promulgate rules to implement this subchapter.

(b) Rules promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary of the United States Department of Health and Human Services under the federal act.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

23-64-614. Relation to other laws. [Contingent effective date.]

(a) This subchapter is amendatory to the Arkansas Insurance Code.

(b) Provisions of the Arkansas Insurance Code that are not in conflict with this subchapter apply to this subchapter.

(c) This subchapter and actions taken by the health insurance marketplace in this state under this subchapter do not preempt or supersede the authority of the Insurance Commissioner to regulate the business of insurance within this state.

(d) Except as expressly provided to the contrary in this subchapter, a health insurer offering a qualified health plan in this state shall comply fully with all applicable health insurance laws of this state and regulations adopted and orders issued by the commissioner.

History. Acts 2013, No. 1439, § 1.

Effective Dates. Acts 2013, No. 1439, § 2: Effective date clause provided: "This act is effective when:

"(1) The United States Department of Health and Human Services or other responsible federal agency or federal official notifies the Governor, the Insurance Commissioner, or other responsible state agency or state official pursuant to the federal healthcare laws established by Pub. L. No. 111-148, as amended by Pub. L. No. 111-152, and any amendments thereto, or regulations or guidance issued under those federal statutes; or

"(2) A health insurance marketplace is initiated and is operable in this state."

CHAPTER 65

UNAUTHORIZED INSURERS AND SURPLUS LINES

SUBCHAPTER.

3. Surplus Lines Insurance Law.

Subchapter 3 — Surplus Lines Insurance Law

23-65-303. Insurer not admitted.

(a) The permission granted in this law to place any insurance in a nonadmitted insurer shall not be deemed or construed to authorize that insurer to otherwise transact an insurance business in this state. Further, this limited permission shall not be deemed or construed so as to exempt nonadmitted insurers from the principles of the common law of insurance or from the same statutory and common law penalties that may attach in favor of insureds in the event of disputes or litigation between insureds and admitted insurers.

(b) A contract of insurance carried out by an unauthorized insurer in violation of this subchapter is voidable at the instance of the insured.

History. Acts 1959, No. 148, § 193; A.S.A. 1947, § 66-2913; Acts 1993, No. 118, § 1; 2011, No. 1055, § 2; 2013, No. 355, § 7.

Amendments. The 2013 amendment substituted "insured" for "insurer" in (b).

23-65-310. Surplus lines in solvent insurers.

(a) A surplus lines broker shall place surplus lines insurance only with insurers that have been approved by the Insurance Commissioner.

(b)(1) The commissioner may maintain a list of approved foreign and alien surplus lines insurers in addition to those alien insurers maintaining status on the current National Association of Insurance Commissioners' nonadmitted insurers' quarterly listing.

(2) The approved list shall not contain:

(A) An insurer that is not licensed in at least one (1) state of the United States for the kind of insurance involved;

(B) A stock insurer having capital and surplus amounting to less than three million dollars ($3,000,000);

(C) A type of insurer, other than stock insurers, having surplus of less than three million dollars ($3,000,000);

(D)(i) An alien insurer, unless:

(a) The insurer has an established and effective trust fund within the United States administered by a recognized financial institution and held for the benefit of its policyholders; and

(b) The trust fund is in the amount of not less than one million dollars ($1,000,000).

(ii)*(a)* The broker may place casualty insurance with an alien insurer or a pool of alien insurers having combined capital and surplus of five million dollars ($5,000,000) or more, so long as the insured signs an affidavit accepting the insurance.

(b) The affidavit shall include a statement that the insurance is not available to him or her elsewhere.

(iii) The alien insurer shall:

(a) Annually report the location and balance of the trust fund to the commissioner as the commissioner prescribes; and

(b) Report to the commissioner any change in the location of the trust fund;

(E) An insurer owned or controlled by a political sovereign or an agency of a political sovereign; or

(F)(i) An insurer that does not maintain on deposit under § 23-63-901 et seq. eligible securities having a market value at all times of at least one hundred thousand dollars ($100,000) conditioned on the payment of creditors or obligees of the insurer in this state and the prompt payment of all claims arising and accruing to any persons during the term of the securities under a policy issued by the insurer.

(ii) This subdivision (b)(2)(F) does not apply to foreign and alien surplus lines insurers as of July 21, 2011, if the requirements of the Nonadmitted and Reinsurance Reform Act of 2010, Pub. L. No. 111-203, as it existed on January 1, 2013, are met.

(c) Upon receipt of a written request from the commissioner, an insurer shall promptly furnish to the commissioner information concerning its transactions or affairs.

History. Acts 1959, No. 148, § 196; 1961, No. 466, § 10; 1973, No. 66, § 7; 1977, No. 789, § 5; 1981, No. 809, § 4; 1983, No. 522, §§ 25, 26; A.S.A. 1947, § 66-2916; Acts 1989, No. 772, §§ 7, 8; 2011, No. 1055, § 2; 2013, No. 355, §§ 8, 9.

Amendments. The 2013 amendment redesignated former (b)(2)(F) as (b)(2)(F)(i); added (b)(2)(F)(ii); and rewrote (c).

23-65-317. Revocation of broker's license.

(a) The Insurance Commissioner shall revoke a surplus lines broker's license:

(1) If the broker fails to file his or her quarterly statement or fails to remit the tax as required by law;

(2) If the broker fails to maintain an office, keep records, or allow the commissioner to examine his or her records as required by law; or

(3) For any cause for which an agent's license may be revoked.

(b) The commissioner may suspend or revoke a license whenever he or she deems the suspension or revocation to be for the best interest of the people of this state.

(c) The procedures provided by § 23-64-218 for the suspension or revocation of an agent's license shall be applicable to suspension or revocation of a surplus lines broker's license.

(d) A broker whose license has been revoked shall not be licensed within one (1) year thereafter or until payment of fines or delinquent taxes.

History. Acts 1959, No. 148, § 203; A.S.A. 1947, § 66-2923; Acts 2001, No. 1555, § 9; 2011, No. 1055, § 2; 2013, No. 1133, § 8.

Amendments. The 2013 amendment, in (a)(1), substituted "quarterly" for "annual" and inserted "fails."

23-65-320. Domestic surplus lines insurers.

(a) A domestic insurer possessing policyholder surplus of at least twenty million dollars ($20,000,000) may be:

(1) Designated as a domestic surplus lines insurer with the written approval of the Insurance Commissioner; and

(2) Allowed to write surplus lines insurance in any jurisdiction in which it is eligible.

(b) A domestic surplus lines insurer is:

(1) Deemed a nonadmitted surplus lines insurer in the State of Arkansas; and

(2) Deemed a nonadmitted surplus lines insurer under the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203.

(c) A domestic surplus lines insurer is not subject to:

(1) The Arkansas Property and Casualty Insurance Guaranty Act, § 23-90-101 et seq.; or

(2) The Arkansas Life and Health Insurance Guaranty Association Act, § 23-96-101 et seq.

(d) A surplus lines broker that obtains surplus lines insurance from a domestic surplus lines insurer shall comply with § 23-65-315.

(e) Unless specifically exempt, the insurance laws of this state regarding financial and solvency requirements apply to a domestic surplus lines insurer.

History. Acts 2011, No. 332, § 1; 2013, No. 157, § 1.

Amendments. The 2013 amendment deleted former (b)(1) and redesignated the remaining subdivisions accordingly; rewrote (d); and added (e).

CHAPTER 66

TRADE PRACTICES

SUBCHAPTER.

5. Fraudulent Insurance Acts Prevention.

Subchapter 5 — Fraudulent Insurance Acts Prevention

SECTION.

23-66-501. Definitions.

As used in this subchapter:

(1) "Actual malice" means knowledge that information is false, or reckless disregard of whether it is false;

(2) "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or are officers, directors, agents, or employees of insurers or who are other persons authorized to act on their behalf;

(3) "Commissioner" means the Insurance Commissioner of this state;

(4) "Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, deceive, conceal, or misrepresent:

(A) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, a reinsurer, broker or its agent, or by a broker or agent, false information as part of, in support of, or concerning a fact material to one (1) or more of the following:

(i) An application for the issuance or renewal of an insurance policy or reinsurance contract;

(ii) The rating of an insurance policy or reinsurance contract;

(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;

(iv) Premiums paid on an insurance policy or reinsurance contract;

(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(vii) The financial condition of an insurer or reinsurer;

(viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

(ix) The issuance of written evidence of insurance; or

(x) The reinstatement of an insurance policy;

(B) Solicits or accepts new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(C) Removes, conceals, alters, or destroys the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance;

(D) Embezzles, abstracts, purloins, or converts moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance;

(E) Transacts the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance;

(F) Attempts to commit, aids or abets the commission of, or conspires to commit the acts or omissions specified in this subsection;

(G) Issues false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance;

(H) Possesses or possesses in order to distribute, solicit, sell, negotiate or effectuate false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance to consumers, lienholders or loss payees, insurance agents or producers, or other persons or entities;

(I) Possesses any device, software, or printing supplies utilized to manufacture false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance; or

(J) Falsely holds himself, herself, or itself out as a representative of an insurance company or assists another in furtherance of that misrepresentation to receive a benefit under an insurance claim, contract, or policy;

(5)(A) "Insurance" means a contract or arrangement in which one undertakes to:

(i) Pay or indemnify another as to loss from certain contingencies called "risks", including through reinsurance;

(ii) Pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies;

(iii) Pay an annuity to another; or

(iv) Act as surety.

(B) "Insurance" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;

(6) "Insurer" means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the acts set forth in subdivision (5)(A) of this section. A person is an insurer regardless of whether the person is acting in violation of laws requiring a certificate of authority or regardless of whether the person denies being an insurer;

(7) "NAIC" means the National Association of Insurance Commissioners;

(8)(A) "Person" means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing.

(B) "Person" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;

(9) "Policy" means an individual or group policy, group certificate, contract, or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state; and

(10) "Reinsurance" means a contract, binder of coverage, including placement slip, or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

History. Acts 1997, No. 217, § 1; 2001, No. 1604, § 45; 2005, No. 1697, § 13; 2013, No. 355, § 10.

Amendments. The 2013 amendment added (4)(J).

23-66-508. Creation and purpose of Criminal Investigation Division.

(a)(1) The Criminal Investigation Division is established within the State Insurance Department and is designated a law enforcement agency.

(2)(A) The Insurance Commissioner shall appoint the full-time supervisory and investigative personnel of the division, who shall be qualified by training and experience to perform the duties of their positions.

(B) A person designated and employed as an investigator for the division shall:

(i) Be a certified law enforcement officer under § 12-9-101 et seq.; and

(ii) Have statewide law enforcement jurisdiction and authority.

(3)(A) The commissioner shall designate the personnel assigned to the division who shall conduct investigations under § 23-66-504 and any criminal violations related to those investigations.

(B) Personnel hired as law enforcement officers shall be state-certified in law enforcement or the equivalent in national or military law enforcement experience as approved by the commission.

(4) The commissioner shall also appoint clerical and other staff necessary for the division to carry out its duties and responsibilities under this subchapter.

(b) It shall be the duty of the division to:

(1) Initiate independent inquiries and conduct independent investigations when the division has cause to believe that a fraudulent insurance act may be, is being, or has been committed;

(2) Review reports or complaints of alleged fraudulent insurance activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and

(3) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

(c) The division shall have the authority to:

(1)(A) Issue subpoenas to examine any individual under oath and to compel the production of records, books, papers, contracts, and other documents.

(B) Subpoenas shall be served in the same manner as if issued by a circuit court.

(C) If any individual fails to obey a subpoena issued and served pursuant to this subsection, upon application of the division, the Pulaski County Circuit Court or the circuit court of the county where the subpoena was served may issue an order requiring the individual to comply with the subpoena.

(D) Any failure to obey the order of the court may be punished by the court as contempt thereof;

(2) Administer oaths and affirmations;

(3) Share records and evidence with federal, state, or local law enforcement or regulatory agencies;

(4)(A) Make criminal referrals to prosecuting authorities.

(B) The prosecuting attorney of the judicial district where a criminal referral has been made shall have, for the purpose of assisting in the prosecution, the authority to appoint as special deputy prosecuting attorneys licensed attorneys in the employment of the division.

(C) The prosecuting attorney shall have the right and discretion to proceed against any person or organization on criminal referrals made hereunder, both organizational and individual liability being intended; and

(5)(A) Conduct investigations outside of this state.

(B) If the information the division seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the division to examine at the place where the information is located.

(C) The division may designate representatives, including officials of the state where the matter is located, to inspect the information on behalf of the division, and the division may respond to similar requests from officials of other states.

History. Acts 1997, No. 217, § 1; 2001, No. 743, § 2; 2005, No. 1697, § 16; 2013, No. 984, § 2.

Amendments. The 2013 amendment inserted "and is designated a law enforcement agency" in (a)(1); in (a)(2), designated paragraph as (a)(2)(A) and inserted (a)(2)(B); and rewrote (a)(3).

CHAPTER 67

RATES AND RATING ORGANIZATIONS

SUBCHAPTER.

6. Interstate Insurance Product Regulation Compact.

Subchapter 6 — Interstate Insurance Product Regulation Compact

SECTION.

A.C.R.C. Notes. Acts 2013, No. 1330, § 1, provided: "Purpose — Findings — Effective date.

"(a) The purpose of this act is to join the other states of the United States that have adopted the Interstate Insurance Product Regulation Compact.

"(b) The General Assembly finds that:

"(1) Under Article XIII, Paragraph 2, of the compact:

"(A) The compact becomes effective and binding upon legislative enactment of the compact into law by two (2) states; and

"(B) The Interstate Insurance Product Regulation Commission becomes effective after adoption of the compact by twenty-six (26) states or by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products;

"(2) Forty (40) states and Puerto Rico have already adopted the compact and represent approximately seventy percent (70%) of the premium volume for life insurance, annuity, disability income, and long-term care insurance products nationwide; and

"(3) The State of Arkansas will join the compact on the effective date of this act."

23-67-601. Title.

This subchapter shall be known and may be cited as the "Interstate Insurance Product Regulation Compact".

History. Acts 2013, No. 1330, § 2.

23-67-602. Adoption of compact.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into with all other jurisdictions legally joining in this compact in the form substantially as follows:

Interstate Insurance Product Regulation Compact

ARTICLE I

PURPOSES

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

2. To develop uniform standards for insurance products covered under the Compact;

3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;

4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the Compact;

6. To create the Interstate Insurance Product Regulation Commission; and

7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II

DEFINITIONS

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a Product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Act.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Non-compacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a Product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for a Product line, pursuant to Article VII of this Compact, and shall include all of the Product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a Product and the form of the Product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III

ESTABLISHMENT OF THE COMMISSION AND VENUE

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance Product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for Product lines, receive and provide prompt review of Products filed therewith, and give approval to those Product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV

POWERS OF THE COMMISSION

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rule-making authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those Products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner Products filed with the Commission, and rate filings for disability income and long-term care insurance Products, and give approval of those Products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rule-making authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or

mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Non-compacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising Members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V

ORGANIZATION OF THE COMMISSION

1. Membership, Voting and Bylaws

a. Each Compacting State shall have and be limited to one Member. Each Member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any Member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each Member shall be entitled to one vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (2/3) of the Members vote in favor thereof.

c. The Commission shall, by a majority of the Members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to

carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each Member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (2/3) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a Member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission

The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification

a. The Members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any Member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any Member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI

MEETINGS AND ACTS OF THE COMMISSION

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each Member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A Member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII

RULES AND OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Act, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish

national uniform consumer protections for the Products subject to this Act; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant Product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition

shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII

COMMISSION RECORDS AND ENFORCEMENT

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Act, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any non-complying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating Procedures. If a non-complying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission,

the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX

DISPUTE RESOLUTION

The Commission shall attempt, upon the request of a Member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two or more Compacting States, or between Compacting States and Non-compacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X

PRODUCT FILING AND APPROVAL

1. Insurers and Third-Party Filers seeking to have a Product approved by the Commission shall file the Product with, and pay applicable filing fees to, the Commission. Nothing in this Act shall be construed to restrict or otherwise prevent an insurer from filing its Product with the insurance department in any State wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall promulgate Rules to establish conditions and procedures under which the Commission will provide public access to Product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a Product filing or supporting information.

3. Any Product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI

REVIEW OF COMMISSION DECISIONS REGARDING FILINGS

1. Not later than thirty (30) days after the Commission has given notice of a disapproved Product or Advertisement filed with the Commission, the Insurer or Third-Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

ARTICLE XII

FINANCE

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third-Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures estab-

lished under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII

COMPACTING STATES, EFFECTIVE DATE, AND AMENDMENT

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, Products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV

WITHDRAWAL, DEFAULT, AND TERMINATION

1. Withdrawal

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in

force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV

SEVERABILITY AND CONSTRUCTION

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI

BINDING EFFECT OF COMPACT AND OTHER LAWS

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any Product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such Products. For Advertisement that is subject to the Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the Product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

History. Acts 2013, No. 1330, § 2.

CHAPTER 68

REHABILITATION AND LIQUIDATION OF INSURANCE COMPANIES

SECTION.

23-68-135. Early distribution.

(a) As used in this section, "distributable asset" means the general assets of an insurer in a liquidation estate except:

(1) Amounts reserved to the extent necessary and appropriate under § 23-68-126(b)(1) as the expenses of the liquidation through and after its closing; and

(2) Amounts reserved to the extent necessary for distribution on claims other than the claims of affected guaranty associations in the priority class of claims under § 23-68-126(b)(2).

(b)(1) An early payment of distributable assets to a guaranty association shall be made:

(A) As frequently as possible after entry of a liquidation order if distributable assets are available, but at least annually; and

(B) In amounts consistent with this section.

(2) An amount distributed to a guaranty association under this section is accounted for as an advance against distributions under § 23-68-126.

(c)(1) Where sufficient distributable assets are available, amounts advanced need not be limited to the claims and expenses paid to date by the guaranty associations.

(2) However, the liquidator shall not distribute distributable assets to the guaranty associations in excess of the anticipated entire claims of the guaranty associations falling within the priority classes of claims established in § 23-68-126(b)(1) and (2).

(d) Within one hundred twenty (120) days after the entry of a liquidation order and at least annually thereafter, the liquidator shall submit to the court:

(1) A financial statement, including:

(A) The assets and liabilities of the insurer;

(B) Any change in the assets and liabilities of the insurer;

(C) The income and expenses of the insurer; and

(D) All funds received or disbursed by the receiver in the liquidation estate during the reporting period;

(2) A report indicating whether or not distributable assets are available based on the financial statement;

(3) If distributable assets are available, a request for court approval to make early access payments of the distributable assets available to affected guaranty associations out of the general assets of the insurer; and

(4) The liquidator may apply to the court to make early access payments more frequently than annually based on additional financial information or the recovery of material assets.

(e) Within sixty (60) days after approval by the court under subdivision (d)(3) of this section, the liquidator shall make early access payments to a guaranty association as indicated in the approved applications.

(f)(1) Notice of each application for early access payments or any report required under this section shall be given to guaranty associations having obligations arising under this section.

(2) At least thirty (30) days before filing a request with the court under subdivision (d)(3) of this section, the liquidator shall provide notice to guaranty associations together with a complete copy of the request.

(3) A guaranty association may:

(A) Request additional information from the liquidator, and the liquidator shall not unreasonably deny the request; and

(B) Object to a request for distribution or any report filed by the liquidator under this section.

(g) In a request for early access payments, the liquidator, at a minimum and based on the information available to the liquidator at the time, shall provide:

(1) The amount reserved for the expenses of the entire liquidation through and after its closure and for distribution on claims in the priority class of claims under § 23-68-126(b)(1) and (2); and

(2) The calculation of distributable assets and the amount and method of equitable allocation of early access payments to guaranty associations.

(h) Each guaranty association that receives any payments pursuant to this section agrees, upon depositing the payment in any account to its

benefit, to return to the liquidator any amount of these payments that may be required to pay claims of secured creditors and claims falling within the priority classes of claims established in § 23-68-126(b)(1) and (2).

(i) A bond is not required of any guaranty association under this section.

(j) Without the consent of affected guaranty associations or an order of the court, the liquidator shall not offset the amount to be distributed to a guaranty association by the amount of a special deposit or other deposit or asset of the insurer held in another state unless the guaranty association has received the deposit or asset.

History. Acts 2013, No. 1327, § 1.